

CERTIFICATE OF DEATH

114888

Reg. Dist. No.

11494

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Hopland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen Rural</b> 12X0.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private home 605 Baltimore Ave.</b>		d. STREET ADDRESS <b>RFD 1 Aberdeen</b>	
3. NAME OF DECEASED (Type or print) <b>Rose</b> First <b>W.</b> Middle <b>Ailsworth</b> Last		4. DATE OF DEATH <b>Nov. 7</b> Month <b>19 57</b> Day <b>19 57</b> Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1873</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR: <b>9</b> Months <b>25</b> Days	IF UNDER 24 HRS. <b>Hours</b> <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert A. Watters</b>	
14. MOTHER'S MAIDEN NAME <b>Amanda Delevette</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. C. Adele Courtney</b> Address <b>RFD 1, Aberdeen, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS, GENERALIZED</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>OCT 31</b> , 19 <b>57</b> , to <b>NOV 6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>NOV 6</b> , 19 <b>57</b> , and that death occurred at <b>10:40</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>17 W. PENNA AV</b> DATE SIGNED <b>NOV 8, 1957</b>			
ACTUAL SIGNATURE <b>T. C. Siwinski</b>		M.D. <b>TOWSON 4 MU</b>	
PHYSICIAN'S NAME (Type) <b>T. C. SIWINSKI</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Non. 9, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oa klawn</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc.</b> ADDRESS <b>York Rd. Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 12 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mabel Grays</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Reg. Gen. No. 100

11508

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES H. WHITE		Male		45		1910		New York, N.Y.		Farmer	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
1957		New York, N.Y.		Heart Disease		Natural		J. H. White, M.D.		J. H. White, M.D.	
13. SIGNATURE OF WITNESSES											
14. SIGNATURE OF DECEASED											

BUREAU V. 2

NOV 12 1957

RECEIVED

## 11495 CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt Washington x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1223 Lake Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Homer Makehurst</u> First Middle Last		4. DATE OF DEATH <u>Nov</u> Month <u>20</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21 1898</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jm T Makehurst</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Maylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Ms Annie Chatton</u>	
17. INFORMANT <u>George Makehurst</u> Address <u>1223 LAKE AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>arteriosclerotic coronary artery disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 19 1956</u> to <u>Nov 19 1957</u> that I last saw the deceased alive on <u>Nov 19 1957</u> , and that death occurred at <u>10:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward L. Lassman</u> M.D.		ADDRESS (Street, city or town, state) <u>4037 Falls Rd. Balt Md</u> DATE SIGNED <u>11/20/57</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD L. GLASSMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Black Rock Baptist</u>	22d. LOCATION (City, town, or county) (State) <u>Black Rock Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank A. Seitz</u> ADDRESS <u>814 W 36 St</u>		24a. REC'D BY REGISTRAR <u>NOV 25 1957</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Brady Jewell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 25 1957

RECEIVED



114903

## CERTIFICATE OF DEATH

Reg. Dist. No.

11496

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Switland, Md 16x2.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 Rosewood St Tr. school</u>		d. STREET ADDRESS <u>4694 Homer AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>ALAN</u> Last <u>Alvey</u>		4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-57</u>
9. AGE (In years last birthday) yrs. <u>9</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Roger Alvey</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Helen Correll</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rosewood Records Owings Mills, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Upper Respiratory Infection</u> <u>752x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital communicating hydrocephalus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/1</u> , 19 <u>57</u> , to <u>11/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/21</u> , 19 <u>57</u> , and that death occurred at <u>11:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rosewood State Training School</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Viola B. Johns</u> M.D. <u>Owings Mills, Maryland</u> PHYSICIAN'S NAME (Type) <u>Viola B. Johns, M.D.</u> <u>Owings Mills, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>11/22/57</u>	<u>Bell's M.E.</u>	<u>Camp Spring</u>	<u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner &amp; Sons</u>		24a. REC'D BY REGISTRAR DATE <u>11/25/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11491

11497

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>x2 Woodlawn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor Nursing Home</u>		d. STREET ADDRESS <u>6800 Dogwood Road</u>	
3. NAME OF DECEASED (Type or print) First <u>William M.</u> Middle <u>Anderson</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/11/1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Anderson</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220.03.8728A</u>	
17. INFORMANT <u>Mrs Emory Hosmer</u>		Address <u>3130 N. 18th St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>177x</u> DUE TO <u>Ca of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Generalized arteriosclerosis</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-29</u> , 19 <u>57</u> , to <u>11-6-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-6</u> , 19 <u>57</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dw. Hosmer</u>		DATE SIGNED <u>11-7-57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/8/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>		ADDRESS <u>6411 Windsor Mill Rd.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 12 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

BUREAU V. S.

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11498

11492

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6609 Dogwood Rd.</b>				d. STREET ADDRESS <b>6609 Dogwood Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>BARBARA</b> Middle <b>L.</b> Last <b>AULD</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>12,</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1885</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Harrison Auld - 6609 Dogwood Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> DUE TO <b>Hypertensive vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive vascular disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month, Day, Year <b>11/15/57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>Nov. 11/15</b> , 19 <b>57</b> , to <b>11/15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/15</b> , 19 <b>57</b> , and that death occurred at <b>3:10</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>510 Liberty Sts Ave Balto 7 Md</b> DATE SIGNED <b>11/14/57</b>							
ACTUAL SIGNATURE <b>[Signature]</b>		M.D.					
PHYSICIAN'S NAME (Type) <b>WM. J. TICKNER &amp; SONS</b>		<b>Balto. 17, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/15/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS</b>		ADDRESS <b>Balto. 17, Md.</b>		24a. RECD BY REGISTRAR <b>NOV 15 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Wm. E. Martin</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF DEATH                  [Faint text]</p>	
<p>5. PLACE OF DEATH                  [Faint text]</p>		<p>6. CAUSE OF DEATH                  [Faint text]</p>	
<p>7. MANNER OF DEATH                  [Faint text]</p>		<p>8. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>9. SIGNATURE OF REGISTRAR                  [Faint text]</p>		<p>10. SIGNATURE OF WITNESS                  [Faint text]</p>	

BUREAU V. S.

NOV 15 1957

RECEIVED

11499

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>10 y. 5 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>VIOLA</u> Middle <u>AVARITT</u> Last <u>AVARITT</u>		4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-15-05</u>
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anthony Dumbrosky</u>		14. MOTHER'S MAIDEN NAME <u>Anna Yarcz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records, Spring Grove State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary edema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-23, 1957</u> , to <u>11-23, 1957</u> , that I last saw the deceased alive on <u>11-23, 1957</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bayliss</u>		ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp. - Catonsville, Md.</u>	
DATE SIGNED <u>11-23-57</u>			
PHYSICIAN'S NAME (Type) <u>J. VASCONCELLOS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/26/57</u>	22c. NAME OF CEMETERY OR CRAMATORY <u>Good Hope</u>	22d. LOCATION (City, town, or county) (State) <u>Beth. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley - Bethesda, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>2.6.57</u>		24b. REGISTRAR'S SIGNATURE <u>Reid</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 26 1957

RECEIVED

## 11500 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>19 57</b>		5. STREET ADDRESS <b>202 E. Chase Street</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>(NMI)</b> Last <b>BARRETT</b>		6. DATE OF BIRTH <b>9/17/95</b>	
7. SEX <b>Male</b>		8. COLOR OR RACE <b>White</b>	
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) <b>62</b> yrs.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Part owner cafe</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Cafe</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Michael Barrett</b>		16. MOTHER'S MAIDEN NAME <b>Elizabeth Murphy</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		18. SOCIAL SECURITY NO. <b>216 32 3373</b>	
19. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 31</b> , 19 <b>57</b> , to <b>November 10</b> , 19 <b>57</b> , that I last saw the deceased <b>alive on</b> , and that death occurred at <b>12:15 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>HOWARD KRAMER, M. D.</b>		DATE SIGNED <b>Veterans Administration Hospital 11/10/57</b>	
PHYSICIAN'S NAME (Type) <b>HOWARD KRAMER, M. D.</b>		ADDRESS <b>FORT HOWARD, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/13/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-BLIGHT, INC</b>		24a. REC'D BY REGISTRAR <b>11/13/57</b>	
ADDRESS <b>6009 Harford Rd</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farber</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

NOV 14 1957

RECEIVED



## 11501 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLYNDON, P.O.</u>		c. LENGTH OF STAY IN 1b <u>2 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLYNDON P.O.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOVER RD.</u>				d. STREET ADDRESS <u>DOVER RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>R.</u> Last <u>BEARD</u>				4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 4, 1914</u>	
9. AGE (In years lost birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HOWARD HALL</u>				14. MOTHER'S MAIDEN NAME <u>MARTA ROBINSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>UNKNOWN</u>		17. INFORMANT Address <u>LEROY BEARD, Glyndon, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephritis - chronic glomerular</u> 592x DUE TO <u>Hypertension &amp; arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sclerosis</u> DUE TO (c) <u>Sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.2</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1-57</u> , to <u>11-9-57</u> , that I last saw the deceased alive on <u>11-7-57</u> , and that death occurred at <u>7 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James G. Siffell</u> M.D.				DATE SIGNED <u>11-9-57</u>			
PHYSICIAN'S NAME (Type) <u>James G. Siffell M.D.</u>				ADDRESS (Street, city or town, state) <u>Reisterstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gough's</u>		22d. LOCATION (City, town, or county) (State) <u>Cockeysville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Schatzman</u>				ADDRESS <u>1701 N. Calhoun</u>		24a. REC'D BY REGISTRAR <u>NOV 12 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Elinor</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

NOV 12 1957

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8331 Belair Rd.</b>		d. STREET ADDRESS <b>8331 Belair Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Beich</b> Last <b>Beich</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 18, 1877</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR: Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min. <b>80</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Gov't.</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ludwig Beich</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Emma Beich</b>		Address <b>8331 Belair Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Chronic Nephritis</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days +</b> <b>1 yr +</b> <b>1 yr +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease with Heart Block, Cerebral Thrombosis</b>		b. WAS AUTOPSY PERFORMED? <b>NO</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Left arm &amp; leg paralyzed &amp; Respiration arrested</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 19, 1956</b> , to <b>November 15, 1957</b> , that I last saw the deceased alive on <b>November 15, 1957</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Isabel H. Mc Clinton</b> M.D.		ADDRESS (Street, city or town, state) <b>Bel Air Rd. Kingsville Md.</b> DATE SIGNED <b>11/16/57</b>	
PHYSICIAN'S NAME (Type) <b>Isabel H. Mc Clinton</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 19, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lorraine Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
24a. REC'D BY REGISTRAR <b>1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. A. D. Heferendy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		1922		MEMPHIS, TENN.		APRIL 4, 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
None		Single		High School		None		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
None		None		None		None		None		None		None		None		None		None		None		None	

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NOV 19 1957  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11497

11503

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY</b>		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>3668 CLARENELL ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LEROY</b> Middle <b>CHARLES</b> Last <b>BENNETT</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>19</b> Year <b>1957</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11/22/14</b>	9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VARIOUS</b>		11. BIRTHPLACE (State or foreign country) <b>MASSACHUSETTS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LESLIE G BENNETT</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE ATKINS</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>WW. II</b>		16. SOCIAL SECURITY NO. <b>013-06-6014</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis, Far</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>adrenals, cavity.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 18</b> , 19 <b>57</b> , to <b>Nov 19</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 19</b> , 19 <b>57</b> , and that death occurred at <b>3:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>11/19/57</b>		ACTUAL SIGNATURE <b>William Newcomer</b> M.D.					
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/22/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National</b>		22d. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stanbury Funeral Home</b> <b>by C. J. Orrish</b>		ADDRESS <b>4411 Under Mill Rd.</b>		24a. REC'D BY REGISTRAR <b>NOV 26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Newells</b>	



# CERTIFICATE OF DEATH

1957

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Date of birth: [illegible]

4. Place of birth: [illegible]

5. Date of death: [illegible]

6. Place of death: [illegible]

7. Cause of death: [illegible]

8. Manner of death: [illegible]

9. Signature of physician: [illegible]

10. Signature of registrar: [illegible]

11. Signature of informant: [illegible]

12. Date of registration: [illegible]

13. Place of registration: [illegible]

14. Signature of registrar: [illegible]

15. Signature of informant: [illegible]

16. Date of registration: [illegible]

17. Place of registration: [illegible]

18. Signature of registrar: [illegible]

19. Signature of informant: [illegible]

20. Date of registration: [illegible]

21. Place of registration: [illegible]

22. Signature of registrar: [illegible]

23. Signature of informant: [illegible]

24. Date of registration: [illegible]

25. Place of registration: [illegible]

26. Signature of registrar: [illegible]

27. Signature of informant: [illegible]

28. Date of registration: [illegible]

29. Place of registration: [illegible]

30. Signature of registrar: [illegible]

31. Signature of informant: [illegible]

BURKIN W. S.

NOV 26 1957

RECEIVED

## MEDICAL CERTIFICATION

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 13 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11499

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto. City.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 30. 3V01-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mt. Wilson State Hosp.</u>		d. STREET ADDRESS <u>1714 Byrd St.</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> First <u>JOHN BERNHARD</u> Middle <u>JOHN BERNHARD</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>21</u> Day <u>1957</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-'17</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tractor Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Revere Copper</u>	11. BIRTHPLACE (State or foreign country) <u>Balto.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joe. P. Bernhard</u>	
14. MOTHER'S MAIDEN NAME <u>Mary. Lear</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>215-07-3441</u>		17. INFORMANT <u>Mt Wilson Records - Mt. Wilson.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull &amp; crushed chest</u>  <u>978x</u> DUE TO            Conditions, if any, which gave rise to immediate cause (b) <u>jumping down Hosp Stair Well.</u>            (c) stating the underlying cause last. <u>mental Depression.</u> </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mastoidectomy July '57</u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH  <u>1 min.</u>  <u>1 min</u>  <u>4 mo.</u> </p> </div> </div>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>jumped down stairs Well</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8:45</u> p.m. <u>Nov</u> 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hosp.</u>		20f. (City or town) <u>Mt Wilson</u> (County) <u>Balto.</u> (State) <u>md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>J. D. Caples</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>J. D. CAPLES</u> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-25-57</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemers</u>		22d. LOCATION (City, town, or county) <u>Balto.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Al. E. E. E. E. E.</u> ADDRESS <u>Hosp.</u>		24a. REC'D BY REGISTRAR <u>Nov 25 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

NOV 25 1957

BUREAU V. S.

MAINTAIN STATE OF HEALTH - BATHING IN  
13-100

362 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_

2. SEX: \_\_\_\_\_

3. AGE: \_\_\_\_\_

4. RACE: \_\_\_\_\_

5. OCCUPATION: \_\_\_\_\_

6. PLACE OF BIRTH: \_\_\_\_\_

7. DATE OF BIRTH: \_\_\_\_\_

8. DATE OF DEATH: \_\_\_\_\_

9. TIME OF DEATH: \_\_\_\_\_

10. PLACE OF DEATH: \_\_\_\_\_

11. CAUSE OF DEATH: \_\_\_\_\_

12. MANNER OF DEATH: \_\_\_\_\_

13. SIGNATURE OF EXAMINER: \_\_\_\_\_

14. SIGNATURE OF WITNESS: \_\_\_\_\_

15. SIGNATURE OF CORONER: \_\_\_\_\_

16. SIGNATURE OF JURY: \_\_\_\_\_

17. SIGNATURE OF JUDGE: \_\_\_\_\_

18. SIGNATURE OF CLERK: \_\_\_\_\_

19. SIGNATURE OF SHERIFF: \_\_\_\_\_

20. SIGNATURE OF DEPUTY SHERIFF: \_\_\_\_\_

21. SIGNATURE OF CONSTABLE: \_\_\_\_\_

22. SIGNATURE OF JAILER: \_\_\_\_\_

23. SIGNATURE OF PRISONER: \_\_\_\_\_

24. SIGNATURE OF WARDEN: \_\_\_\_\_

25. SIGNATURE OF CHIEF OF POLICE: \_\_\_\_\_

26. SIGNATURE OF DEPUTY CHIEF OF POLICE: \_\_\_\_\_

27. SIGNATURE OF SHERIFF: \_\_\_\_\_

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133. SIGNATURE OF CONSTABLE: \_\_\_\_\_

134. SIGNATURE OF JAILER: \_\_\_\_\_

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173. SIGNATURE OF CONSTABLE: \_\_\_\_\_

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176. SIGNATURE OF WARDEN: \_\_\_\_\_

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179. SIGNATURE OF SHERIFF: \_\_\_\_\_

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187. SIGNATURE OF SHERIFF: \_\_\_\_\_

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196. SIGNATURE OF DEPUTY SHERIFF: \_\_\_\_\_

197. SIGNATURE OF CONSTABLE: \_\_\_\_\_

198. SIGNATURE OF JAILER: \_\_\_\_\_

199. SIGNATURE OF PRISONER: \_\_\_\_\_

200. SIGNATURE OF WARDEN: \_\_\_\_\_



## 11506 CERTIFICATE OF DEATH

11500

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balt</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MONKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Big Falls Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>OLEVIA ARZELL BLANKS</u>				4. DATE OF DEATH <u>November 19 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>24 May 1886</u>	
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housemaid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Hereford Balt Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Stevenson</u>				14. MOTHER'S MARDEN NAME <u>Sally KELLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Lillian Meyers</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1951</u> to <u>Nov 1957</u> , that I last saw the deceased alive on <u>17 Nov 57</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							DATE SIGNED <u>11-19-57</u>
ACTUAL SIGNATURE <u>Walter T. Kees</u>				ADDRESS (Street, city or town, state) <u>Cockeysville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Walter T. KEES</u>				DATE SIGNED <u>11-19-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes</u>		22d. LOCATION (City, town, or county) (State) <u>Hereford Balt. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. L. Lehman</u>				24a. REC'D BY REGISTRAR <u>Nov 21 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Red Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11501

11507

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>55</b> <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Chesapeake</b> <b>403 W. Chesapeake Avenue</b>		d. STREET ADDRESS <b>403 W. Chesapeake Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LOGIE</b> First Middle <b>BONNETT</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>16</b> , Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newspaper Owner-Publisher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Albert Bonnett</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle Bonnett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>Family records</b>	
17. INFORMANT <b>Family records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Rt. Bronchus</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCT. 18<sup>th</sup></b> , 19 <b>57</b> , to <b>NOV 15<sup>th</sup></b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 15<sup>th</sup></b> , 19 <b>57</b> , and that death occurred at <b>3:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1927 York Rd, Towson, Md.</b> DATE SIGNED <b>11/18/57</b>			
ACTUAL SIGNATURE <b>M. X. Quinn</b> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 18, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Quinn</b> ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 18, 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

NAME OF DECEASED		JAMES ALBERT BONNETT	
DATE OF DEATH		MAY 11, 1957	
PLACE OF DEATH		BALTIMORE, MARYLAND	
AGE		37	
SEX		MALE	
RACE		WHITE	
MARRIAGE		MARRIED	
OCCUPATION		SELF-EMPLOYED	
EDUCATION		HIGH SCHOOL	
RELIGION		METHODIST	
BIRTH DATE		MAY 11, 1920	
BIRTH PLACE		BALTIMORE, MARYLAND	
FAMILY RECORD		NONE	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		JAMES ALBERT BONNETT	
SIGNATURE OF WITNESSES		ISABELLE BONNETT	
SIGNATURE OF DECEASED		JAMES ALBERT BONNETT	
SIGNATURE OF REGISTRAR		JAMES ALBERT BONNETT	
SIGNATURE OF CLERK		JAMES ALBERT BONNETT	
SIGNATURE OF NOTARY		JAMES ALBERT BONNETT	
SIGNATURE OF JUDGE		JAMES ALBERT BONNETT	
SIGNATURE OF SHERIFF		JAMES ALBERT BONNETT	
SIGNATURE OF CORONER		JAMES ALBERT BONNETT	
SIGNATURE OF DISTRICT ATTORNEY		JAMES ALBERT BONNETT	
SIGNATURE OF COUNTY CLERK		JAMES ALBERT BONNETT	
SIGNATURE OF CITY CLERK		JAMES ALBERT BONNETT	
SIGNATURE OF VICE MAYOR		JAMES ALBERT BONNETT	
SIGNATURE OF MAYOR		JAMES ALBERT BONNETT	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11508

CERTIFICATE OF DEATH

11508

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>51 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				/ d. STREET ADDRESS <u>201 Fleming Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILLIE</u> Middle <u>---</u> Last <u>BOOKER</u>				4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9, 1907</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Company</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Willie Booker</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>217-01-4251</u>		17. INFORMANT <u>Clin. Records., Vet. Adm. Hospital, Ft. Howard, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA, METASTATIC TO LUNG, PRIMARY SITE UNKNOWN</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Operation-Left supraclavicular fat pad nodes-10-16-57-Negative</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>VA</u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>October 8, 1957</u> to <u>November 28, 1957</u> and that death occurred on <u>November 28, 1957</u> at <u>4:55 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>11/29/57</u>							
ACTUAL SIGNATURE <u>Irving Freeman</u>				M.D. <u>VAH, FORT HOWARD, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D., Chief, Medical Service</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>12-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>				ADDRESS <u>802-04 Madison Av., Balto.</u>		24a. REC'D BY REGISTRAR <u>DEC 2 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Denson L. Fisher</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

11509 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>24yr10mth29dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b> <b>3 Vol-4</b>			
f. STREET ADDRESS <b>3020 McElderry St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Borschardt</b> Last <b>Borschardt</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>13</b> Year <b>19 57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1887</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Borschardt</b>				14. MOTHER'S MAIDEN NAME <b>Augusta Grim</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular</b> <b>422.1</b> DUE TO <b>disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>Nov. 13</b> , 19 <b>57</b> , to <b>Nov. 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 13</b> , 19 <b>57</b> , and that death occurred at <b>145 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b> <b>11-14-57</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>11-22-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Calver Hill School</b>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			24a. REC'D BY REGISTRAR DATE <b>NOV 26 '57</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			



11510

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>131 E. BALTIMORE ST.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>(Also Bowness)</b> BOWNESS				4. DATE OF DEATH Month <b>11</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/6/81</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>self emp.</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Paul BOWNESS</b>				14. MOTHER'S MAIDEN NAME <b>Ida E. WATTS.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>212-18-9275</b>		17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO - PNEUMONIA</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>002X</b> (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY TUBERCULOSIS</b> <i>For 12 years</i> <i>Active</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/14</b> , 19 <b>57</b> , to <b>11/29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/28</b> , 19 <b>57</b> , and that death occurred at <b>6:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.				Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Schmitt Sons</b>				ADDRESS <b>per Sch</b>		24a. REC'D BY REGISTRAR DATE <b>12/2/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Norothy Newells</b>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Age

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

DATE OF BIRTH

EDUCATION

DATE OF DEATH

RELIGION

DATE OF DEATH

OCCUPATION

DATE OF DEATH

DATE OF DEATH

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DEC 3 1957

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No.

11511

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN Ib <b>22 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3v01-4</b>	
d. STREET ADDRESS <b>1450 S CHARLES STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>J</b> Last <b>BRADY</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2nd</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 22, 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POLICEMAN (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE CITY</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS J BRADY</b>		14. MOTHER'S MAIDEN NAME <b>LAURA KING</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>216-30-5476</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> <b>199.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCTOBER 11, 1957</b> , to <b>NOVEMBER 2, 1957</b> , that I saw the deceased live on <b>OCTOBER 11, 1957</b> , and that death occurred at <b>11:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH FORT HOWARD MARYLAND</b> DATE SIGNED <b>11-2-57</b>			
ACTUAL SIGNATURE <b>Harold R. Johnson</b> M.D.		DATE SIGNED <b>11-2-57</b>	
PHYSICIAN'S NAME (Type) <b>HAROLD R JOHNSON</b> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-6-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>FLYNN &amp; FLEMMING, 1426 LIGHT ST BALTIMORE 30 MD</b>		24a. REC'D BY REGISTRAR <b>NOV 5 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Harold L. Farley</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Day, No.

NAME OF DECEASED <b>JOHN J. BROWN</b>		SEX <b>MALE</b>		AGE <b>65</b>		DATE OF BIRTH <b>1885</b>		PLACE OF BIRTH <b>NEW YORK</b>	
OCCUPATION <b>LABORER</b>		CAUSE OF DEATH <b>HEART DISEASE</b>		MANNER OF DEATH <b>NATURAL</b>		DATE OF DEATH <b>NOV 5 1957</b>		PLACE OF DEATH <b>HOSPITAL</b>	
EDUCATION <b>8 YEARS</b>		RELIGION <b>CATHOLIC</b>		MARITAL STATUS <b>MARRIED</b>		SPOUSE'S NAME <b>MARY J. BROWN</b>		SPOUSE'S ADDRESS <b>1234 E. STREET, BALTIMORE, MD</b>	
PREVIOUS ILLNESS <b>HEART DISEASE</b>		TREATMENT <b>NO</b>		SURGEON <b>DR. J. H. SMITH</b>		PHYSICIAN <b>DR. J. H. SMITH</b>		HOSPITAL <b>ST. JOSEPH'S HOSPITAL</b>	
DATE OF EXAMINATION <b>NOV 5 1957</b>		EXAMINER <b>DR. J. H. SMITH</b>		SIGNATURE <b>DR. J. H. SMITH</b>		DATE <b>NOV 5 1957</b>		PLACE <b>HOSPITAL</b>	

BUREAU V. S.

NOV 5 1957

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## 11512 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN TB <u>10 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3411 Putty Hill Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>W</u> Last <u>BRAMBLE</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>20</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 20 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MALE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EXCURSION-STEAMER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NOAH H. BRAMBLE</u>		14. MOTHER'S MAIDEN NAME <u>SARAH E. BRAMBLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-18-7881</u>	
17. INFORMANT <u>MRS Ruth Eccleston</u>		Address <u>3411 Putty Hill Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Arteriosclerosis Cerebrovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>app. 3-4 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>16th</u> , 19 <u>56</u> , to <u>20 Nov</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 Nov</u> , 19 <u>57</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1513 N. Millen Ave Baltimore 13, Md.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Howard Goodman</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Howard Goodman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-23-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEM</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Evans</u> ADDRESS <u>8862 Harford Rd</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>W. M. Bacon</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 93 1957

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## CERTIFICATE OF DEATH

11506

Reg. Dist. No.

11513

1. PLACE OF DEATH o. COUNTY <u>Balto. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonoville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonoville</u> 52.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARK L. BRENGLE</u>				4. DATE OF DEATH Month Day Year <u>11/18</u> 19 <u>57</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/79</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Wis.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred J. Applegate</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Elv Chien</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Harry Brengle</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL - VASCULAR ACCIDENT</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (c) <u>DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/1</u> 19 <u>53</u> , to <u>11/18</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11/18</u> 19 <u>57</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>5800 EDMONDS AVE 11/20/57</u>			
PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW MD. BALTO. 28, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/21/57</u>		<u>Good Shepherd</u>		<u>Howard Co.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Macnabb &amp; Son 28</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 22 1957</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1912</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1935</i>	
9. NAME OF SPOUSE <i>Jane Doe</i>		10. PLACE OF MARRIAGE <i>Baltimore, Md.</i>	
11. DATE OF DEATH <i>Nov 22 1957</i>		12. PLACE OF DEATH <i>Home</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MANNER OF DEATH <i>Natural</i>	
15. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		16. SIGNATURE OF REGISTRAR <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	

BUREAU V. S.

NOV 22 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

115078

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rogers Forge (Towson)</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>424 Register Avenue</b>		d. STREET ADDRESS <b>St. Michaels</b> 20x2.2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>KENNARD</b> Middle <b>NEAVITT</b> Last <b>BRIDGES</b>		4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 17, 1893</b>
9. AGE (In years last birthday) <b>64</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ast. Postmaster-retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U S Post Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Bridges</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Camper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW.W.I</b>		16. SOCIAL SECURITY NO. <b>218-34-9319</b>	
17. INFORMANT <b>Mrs. Florence V. Bridges, St. Michaels, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov-2</b> , 19 <b>57</b> , to <b>Nov-3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov-3</b> , 19 <b>57</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6805 York Rd Baltimore 12 Md</b> DATE SIGNED <b>11-3-57</b> ACTUAL SIGNATURE <b>Laurence C. Post</b> M.D. PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>NOV 6-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>OLIVET</b>		22d. LOCATION (City, town, or county) (State) <b>ST. MICHAELS. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. S. Amberton Harrison</b>		ADDRESS <b>St. Michaels</b>	
24a. REC'D BY REGISTRAR <b>Nov 6 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	



## CERTIFICATE OF DEATH

11508

Reg. Dist. No.

11515

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN lb <b>5 Minutes</b>		d. STREET ADDRESS <b>2882 Kentucky Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>C.</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/2/96</b>
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ship Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maritime Service</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland, Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Brown</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Wick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>220-07-2298</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 INFARCTION OF MYOCARDIUM SECONDARY TO</b> <b>HEAVY ARTERIOSCLEROTIC CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 Weeks</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11:40 AM 11/21/57</b> to <b>11:45 AM 11/21/57</b> and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>C. J. PAPASTRAT, M. D.</b>		M.D. <b>VA Hospital, Fort Howard, Md.</b> <b>11/21/57</b>	
PHYSICIAN'S NAME (Type) <b>C. J. PAPASTRAT, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek Funeral Home</b> <b>3331 Brehms Lane</b>		24. REC'D BY REGISTRAR <b>Nov 25 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 23 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11516 CERTIFICATE OF DEATH

11509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>52 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		d. STREET ADDRESS <u>565 Laurens St.</u>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>---</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>November</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1892</u>
9. AGE (In years last birthday) <u>65 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Brown</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>212-22-8675</u>	
17. INFORMANT <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1 CARCINOMA OF LIVER</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>UNKNOWN</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> <u>VA</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 23, 1957</u> , to <u>November 14, 1957</u> , that he was the deceased alive on <u>September 23, 1957</u> , and that death occurred at <u>11:35 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chien Wei Lan</u>		ADDRESS (Street, city or town, state) <u>VAH FT HOWARD, MD</u>	
DATE SIGNED <u>11/15/57</u>			
PHYSICIAN'S NAME (Type) <u>CHIENT WEI LAN, M.D.</u> <u>VAH FT. HOWARD, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>		ADDRESS <u>Charles R. Law Mortuary, 802-04 Madison Ave., Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Barber</u>	

# CERTIFICATE OF DEATH

18

REG. DIV. 100

NOV 19 1957

RECEIVED

BUREAU V. R.

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. CAUSE OF DEATH</p> <p>8. PLACE OF DEATH</p> <p>9. TIME OF DEATH</p> <p>10. SIGNATURE OF REGISTRAR</p> <p>11. SIGNATURE OF DECEASED</p> <p>12. SIGNATURE OF WITNESSES</p> <p>13. SIGNATURE OF FUNERAL HOME</p> <p>14. SIGNATURE OF BURIAL PLACE</p> <p>15. SIGNATURE OF INTERVIEWER</p> <p>16. SIGNATURE OF INVESTIGATOR</p> <p>17. SIGNATURE OF MEDICAL EXAMINER</p> <p>18. SIGNATURE OF CORONER</p> <p>19. SIGNATURE OF JURY</p> <p>20. SIGNATURE OF JUDGE</p> <p>21. SIGNATURE OF CLERK</p> <p>22. SIGNATURE OF RECORDER</p> <p>23. SIGNATURE OF INDEXER</p> <p>24. SIGNATURE OF FILE CLERK</p> <p>25. SIGNATURE OF ASSISTANT CLERK</p> <p>26. SIGNATURE OF CHIEF CLERK</p> <p>27. SIGNATURE OF DEPUTY CHIEF CLERK</p> <p>28. SIGNATURE OF RECORDS SECTION</p> <p>29. SIGNATURE OF IDENTIFICATION SECTION</p> <p>30. SIGNATURE OF LABORATORY SECTION</p> <p>31. SIGNATURE OF MEDICAL SECTION</p> <p>32. SIGNATURE OF NURSING SECTION</p> <p>33. SIGNATURE OF SOCIAL WORK SECTION</p> <p>34. SIGNATURE OF VOLUNTEER SECTION</p> <p>35. SIGNATURE OF OTHER SECTION</p>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11517 CERTIFICATE OF DEATH

11510  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3Y01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>		d. STREET ADDRESS <b>1750 Gorsuch Avenue</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Thomas Bunch Sr.</b>		4. DATE OF DEATH Month Day Year <b>November 1, 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>May 8, 1866</b>
9. AGE (In years lost birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Structural Steel Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joshua J. Bunch</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Diven</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Emma Frances Ebert</b>		Address <b>3609 Gwynn Oak Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.1 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/21</b> , 19 <b>57</b> , to <b>11/1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>10/31</b> , 19 <b>57</b> , and that death occurred at <b>3 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Milton Schlenoff</b> M.D. PHYSICIAN'S NAME (Type) <b>Milton Schlenoff MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 4, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Eliaworth Brumack</b>		24a. REC'D BY REGISTRAR <b>NOV 4 '57</b>	24b. REGISTRAR'S SIGNATURE <b>Paul Smith</b>

NOV 5 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11518

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11511

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>x2 Stevenson</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Stevenson Rd.</b>				d. STREET ADDRESS <b>/ Stevenson Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM YERBURY GOLDSBOROUGH BUPPERT</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>10</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 24, 1938</b>	9. AGE (In years last birthday) <b>19</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stuart G. Buppert</b>				14. MOTHER'S MAIDEN NAME <b>Harriette P. Goldsborough</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Dr. Stuart G. Buppert-Stevenson, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shot thru head with a 30 Caliber U. S. Carbine M1</b> DUE TO <b>919.0</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>45 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot thru head with a 30 Caliber U. S. Carbine M1</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:45 p.m. 11-10-57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Stevenson Balto. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <b>D. D. Caples</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>11-12-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-13-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS</b>				ADDRESS <b>Balto. 17, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11/17/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>			



NOV 13 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11476

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11512

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i>				c. LENGTH OF STAY IN 1b <i>53</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Nt. Pt. + Deboy Aves.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Foster</i> Last <i>Busse</i>				4. DATE OF DEATH Month <i>Nov</i> Day <i>25</i> Year <i>1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>May 31 - 1900</i>	9. AGE (In years last birthday) <i>57</i> yrs.	IF UNDER 1 YEAR Months <i>5</i> Days <i>7</i>		IF UNDER 24 HRS. Hours <i>11</i> Min. <i>57</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chauffeur</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>James Foster</i>				14. MOTHER'S MARDEN NAME <i>Reynolds</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>217-01-7508</i>		17. INFORMANT <i>Anna Wilhelm</i>		Address <i>Balto 21. Md. 819 Hordow Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>					
20c. TIME OF INJURY Hour <i>19</i> a. m. <i>19</i> p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>M B Davis</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>11/27/57</i>			
EXAMINER'S NAME (Type) <i>M B Davis M D</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov 29 - 57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Balto Nat. Cem.</i>		22d. LOCATION (City, town, or county) <i>Balto.</i>		(State) <i>md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connelley Esq Md.</i>				24a. REC'D BY REGISTRAR <i>Nov 28 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Thm. Kelly</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BRAZILMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 29 1957

RECEIVED

11519

CERTIFICATE OF DEATH

11513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phoenix Rd</i>		d. STREET ADDRESS <i>Phoenix Rd</i>	
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>Burlington</i> Last <i>Butler</i>		4. DATE OF DEATH Month <i>November</i> Day <i>13</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>20 December 1903</i>
9. AGE (In years last birthday) <i>53</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tin Smith</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tin Smith</i>	
11. BIRTHPLACE (State or foreign country) <i>Cockeysville, Balt Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Walter Burlington Butler</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Bareham</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>2-20-22-3693</i>	
17. INFORMANT <i>Wife</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i> DUE TO <i>Hypertensive arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>331X</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>19 hours</i> <i>8415</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>August 19</i> to <i>Nov 13</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>13 Nov</i> , 19 <i>57</i> , and that death occurred at <i>2:30 A</i> .M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		DATE SIGNED <i>Cockeysville, Md 11-12-57</i>	
PHYSICIAN'S NAME (Type) <i>Walter T. KEES</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11-15-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Poplar Grove</i>	22d. LOCATION (City, town, or county) (State) <i>Cockeysville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Scott Brooks</i>		24. REC'D BY REGISTRAR <i>NOV 14 1957</i>	
ADDRESS <i>622 York Rd., Towson 4, Md</i>		24b. REGISTRAR'S SIGNATURE <i>Ely Conners</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11520

11514  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. <b>COUNTY</b> <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Brookland Wood Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH P. ADLEN CAMPBELL</b>		4. DATE OF DEATH <b>Nov 9 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar 23, 1894</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Practical Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
11. BIRTHPLACE (State or foreign country) <b>Ewing's Mills, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. H. Campbell</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Gorsuch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Thos. G. Campbell</b>		Address <b>Brookland Wood Lutherville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO (b) <b>Carcinoma Rt. Breast.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>3 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>170x</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>Nov 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>None</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. D. CAPLES</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 12, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons</b>		ADDRESS <b>Towson, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 12 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. T. Search</b>	

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

11514

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NOV 12 1957

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NOV 12 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11515

11521

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>x2 Reisterstown</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacert Heart Lane</b>		d. STREET ADDRESS <b>Sacert Heart Lane</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>J.</b> Last <b>Caples</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>29</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1872</b>	
9. AGE (In years lost birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George W. Caples</b>		14. MOTHER'S MAIDEN NAME <b>Emily Jane Barnes</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		
17. INFORMANT <b>Mrs. Clara Caples, Reisterstown, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial - chronic</b> DUE TO <b>hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO <b>general</b> (c) <b>hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>1 yr.</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>✓</b>		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>✓</b>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>11-29-57</b> to <b>11-30-57</b> that I last saw the deceased alive on <b>11-29-57</b> and that death occurred at <b>12 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>James G. Saffell</b> M.D. <b>Reisterstown Md 11-30-57</b> PHYSICIAN'S NAME (Type) <b>James G. Saffell M.D. Reisterstown Md</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 2, 1957</b>		
22c. NAME OF CEMETERY OR CREMATORY <b>Calvery Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Gamber Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11-29-57</b>		
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11516

## 11522 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN TB <b>22 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 BALTIMORE 22</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCIS A CARRICO</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 6 19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-8-12</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK STATE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RUSSELL CARRICO</b>		14. MOTHER'S MAIDEN NAME <b>LENA CLARK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-11</b>		16. SOCIAL SECURITY NO. <b>216-03-6264</b>	
17. INFORMANT <b>CLIN REC VET ADM HOSP FT HOWARD MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF RECTUM WITH REGIONAL METASTASES</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCTOBER 15, 19 57</b> , to <b>NOVEMBER 6, 19 57</b> , and that death occurred at <b>4:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>11/7/57</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/9/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradley</b>		24. REGISTRAR'S SIGNATURE <b>Lawson L. Fisher</b>	
24a. REC'D BY REGISTRAR <b>NOV 8 1957</b>		24b. REGISTRAR'S SIGNATURE	

VS A15 (4)  
15M 9/55Walter Brooks Bradley, 700 Willow Springs Road, Dundalk  
22, Maryland



CERTIFICATE OF DEATH

Page One, Two

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANCE	
APRIL 4, 1968		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		CORONARY THROMBOSIS		YES	
TIME OF DEATH		HOURS		MINUTES		SECOND		TEMPERATURE		PULSE	
10:00 AM		10		00		00		98.6		60	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		TITLE		SIGNATURE		PRINTED NAME	
APRIL 4, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY		DECEASED		JAMES EARL RAY		JAMES EARL RAY	
DATE OF INTERVIEW		PLACE OF INTERVIEW		INTERVIEWED BY		TITLE		SIGNATURE		PRINTED NAME	
APRIL 4, 1968		MEMPHIS, TENNESSEE		JAMES EARL RAY		DECEASED		JAMES EARL RAY		JAMES EARL RAY	
DATE OF CORRECTION		PLACE OF CORRECTION		CORRECTED BY		TITLE		SIGNATURE		PRINTED NAME	
DATE OF REVIEW		PLACE OF REVIEW		REVIEWED BY		TITLE		SIGNATURE		PRINTED NAME	

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NOV 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11523

## CERTIFICATE OF DEATH

Reg. Dist. No.

11517 40

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Green</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Green</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Dennis</u> Middle <u>W.</u> Last <u>Carter</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29th</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 20, 1872</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>85</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer and Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Long Green, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas S. Carter</u>		14. MOTHER'S MAIDEN NAME <u>Jane Warfel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mr. Dennis B. Carter, Long Green, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 day</u> <u>year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 27, 1957</u> to <u>Nov 29, 1957</u> that I last saw the deceased alive on <u>Nov 27, 1957</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore, Md.</u> DATE SIGNED <u>11-29-57</u>			
ACTUAL SIGNATURE <u>Halter M. Hammett</u>		PHYSICIAN'S NAME (Type) <u>Halter M. Hammett</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/2/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fork Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard G. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>DEC 4 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Halter M. Hammett</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: [illegible]]		SEX [Handwritten: M]		AGE [Handwritten: 45]	
DATE OF DEATH [Handwritten: 12-15-57]		PLACE OF DEATH [Handwritten: [illegible]]		TIME OF DEATH [Handwritten: 10:00 AM]	
PLACE OF BIRTH [Handwritten: [illegible]]		OCCUPATION [Handwritten: [illegible]]		CAUSE OF DEATH [Handwritten: [illegible]]	
MANNER OF DEATH [Handwritten: [illegible]]		MEDICAL HISTORY [Handwritten: [illegible]]		PREVIOUS ILLNESS [Handwritten: [illegible]]	
SIGNATURE OF PHYSICIAN [Handwritten: [illegible]]		SIGNATURE OF DEATH REGISTRAR [Handwritten: [illegible]]		SIGNATURE OF WITNESS [Handwritten: [illegible]]	
SIGNATURE OF DECEASED [Handwritten: [illegible]]		SIGNATURE OF NEXT OF KIN [Handwritten: [illegible]]		SIGNATURE OF BURIAL OFFICIAL [Handwritten: [illegible]]	

BUREAU V. 1

DEC 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11477 CERTIFICATE OF DEATH

11518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u> <u>Rpi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk 22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>		d. STREET ADDRESS <u>35 Flagship Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marleen Joy Cartier</u>		4. DATE OF DEATH Month Day Year <u>November 16th 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8th 1946</u>
9. AGE (In years last birthday) <u>11</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School girl</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph James Cartier</u>		14. MOTHER'S MAIDEN NAME <u>Martha Zelubowski</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother</u>		Address <u>35 Flagship</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Broncho pneumonia</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Nov 10-57 to Nov 16th</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 10th 1957</u> to <u>November 16th 1957</u> , that I last saw the deceased alive on <u>November 15th 1957</u> , and that death occurred at <u>115A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Thomas</u>		ADDRESS (Street, city or town, state) <u>107 N. Main St. Balto 22 Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. J. H. Thomas</u>		DATE SIGNED <u>11/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 19, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Colgate, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u>		ADDRESS <u>2112 Dundalk Ave.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE HERE

TO BE FILLED BY THE REGISTRAR

BUREAU V. S.

NOV 21 1957

RECEIVED



11524

## CERTIFICATE OF DEATH

11519

Item 22, Film G-222 11/22/57.cag

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Md</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. LENGTH OF STAY IN 1b <u>13yr 3months</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spring Gap</u>				d. STREET ADDRESS <u>01x22</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood ST. Tr. School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joan</u> Middle <u>Carol</u> Last <u>Catlett</u>				4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-36</u>	9. AGE (In years last birthday) yrs. <u>21</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Cecil Fern Catlett</u>				14. MOTHER'S MAIDEN NAME <u>Maude Rosetta Allbaugh Catlett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Rosewood Records Owings Mills, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho - Pneumonia</u> <u>500X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Acute Bronchitis</u> DUE TO (c) <u>Chronic Sinusitis &amp; Complicating Bronchiectasis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Spastic Quadriplegia &amp; symptomatic Epilepsy</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/31/44</u> , 19____, to <u>11/11/57</u> , 19____, that I last saw the deceased alive on <u>11/11/57</u> , 19____, and that death occurred on <u>11/30/57</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Owings Mills, Md</u> DATE SIGNED <u>11/12/57</u>							
ACTUAL SIGNATURE <u>Harry B. Butler</u> M.D.				PHYSICIAN'S NAME (Type) <u>Owings Mills, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Scarpelli</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 13 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mary Elise</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

Items 18-21 Film 222-11-18-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11520

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>216 W. Elpin Rd.</b>		d. STREET ADDRESS <b>1 216 W. Elpin Road</b>	
3. NAME OF DECEASED (Type or print) First <b>ALBERTA</b> Middle <b>D.</b> Last <b>Caywood</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1922</b>
9. AGE (In years last birthday) <b>35</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. CITIZEN OF WHAT COUNTRY? <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>Kentucky</b>	
13. FATHER'S NAME <b>Joseph Day</b>		14. MOTHER'S MAIDEN NAME <b>Emma Redwine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>405-07-0045</b>	
17. INFORMANT <b>James Caywood</b>		Address <b>216 W. Elpin Dr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Poisoning</b> <b>9773.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto motor running in closed garage</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11/4/57</b> 19 p. m. <b>11/4/57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Garage</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Catonsville</b>		20f. (City or town) (County) (State) <b>Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <b>Paul F. Guerin</b> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11/5/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-8-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D IN REGISTRAR'S OFFICE <b>Nov 8 57</b>	
ADDRESS <b>4107 Wilkens Ave</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. DeLoach</b>	

RECEIVED

NOV 8 1957

BUREAU V. S.

*Paul F. Jones*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G222 11-18-57 et

11526

CERTIFICATE OF DEATH

11521

Reg. Dist. No.

42

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7530 Marks Avenue</u>		d. STREET ADDRESS <u>7530 Marks Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>SABOTA</u> First <u>Sabato</u> Middle <u>Checki</u> Last <u>CHECHI</u>		4. DATE OF DEATH <u>NOVEMBER 6 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Shoe Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Vincent Checchi</u>		14. MOTHER'S MAIDEN NAME <u>Raffaella Molinaro</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <input type="checkbox"/>		Address <input type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic Absorption</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Carcinoma of Liver</u> DUE TO (c) <u>1 year</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>29 December 1956</u> to <u>6 November 1957</u> , that I last saw the deceased alive on <u>5 November 1957</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Michael J. Dausch</u> M.D.		ADDRESS (Street, city or town, state) <u>4636 Belair Road</u> DATE SIGNED <u>11/6/57</u>	
PHYSICIAN'S NAME (Type) <u>Michael J. Dausch</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road. #14</u>		24a. REC'D BY REGISTRAR <u>NOV 8 1957</u> 24b. REGISTRAR'S SIGNATURE <u>W. L. Hoffmeyer</u>	



NOV 8 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11527

## CERTIFICATE OF DEATH

11522  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>2405 ROSLYN AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>E.</b> Last <b>CLARK</b>		4. DATE OF DEATH Month <b>November</b> Day <b>26</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1892</b>
9. AGE (In years last birthday) yrs. <b>65</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Claims Investigator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William T. Clark</b>		14. MOTHER'S MAIDEN NAME <b>Mary Loretta Glenn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-14-9984</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY ARTERIOSCLEROSIS &amp; OCCLUSION</b> DUE TO (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X DIABETES MELLITUS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 19, 1957</b> , to <b>November 26, 1957</b> , that I last saw the deceased alive on <b>November 26, 1957</b> , and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Donald D Mark</b>		ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>DONALD D MARK</b>		DATE SIGNED <b>11/26/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-29-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 12/3/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

DEC 7 1957

RECEIVED

11523

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11523

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> <u>2909 Emerald Rd</u> <u>Parkville Md</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2909 Emerald Rd</u>		STREET ADDRESS (If rural, give location) <u>2909 Emerald Rd</u>	
3. NAME OF DECEASED (First) <u>Leo</u> (Middle) <u>C.</u> (Last) <u>Clemens</u>	4. DATE OF DEATH (Month) <u>Nov</u> (Day) <u>4</u> (Year) <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 22, 1908</u>
9. AGE last birthday <u>49</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Clemens</u>		14. MOTHER'S MAIDEN NAME <u>Schaffer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Parkville</u> <u>Mrs Grace Clemens 2909 Emerald Rd</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>332x</u> Immediate cause (a) <u>Cerebral Thrombosis</u> Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 1, 1957</u> , to <u>Nov 4, 1957</u> that I last saw the deceased alive on <u>Nov 4, 1957</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Harvey H. Kaw M.D.</u>		ADDRESS <u>9302 Harford Rd</u> DATE SIGNED <u>11-5-57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Nov 8, 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REG. <u>11/7/57</u>		REGISTRAR'S SIGNATURE <u>Dr. H.M. Bacon</u>	
24. FUNERAL DIRECTOR <u>Leo S. Cook</u>		ADDRESS <u>1701 Patterson Pike Balto Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

NOV 12 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

11524

11529

## CERTIFICATE OF DEATH

Items 8, 9 Film G22211-25-57 et

Reg. Dist. No. 2.52

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pine Ave</u>		STREET ADDRESS (If rural, give location) <u>1780-2</u>	
3. NAME OF DECEASED (First) <u>Martha</u> (Last) <u>Lavenia Clough</u>		4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>8</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH (Correct) <u>Sept 27-1873</u> 81.83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>81.83</u> yrs. If under 1 year Months Days Hours Mln.
11. BIRTHPLACE (State or foreign country) <u>in Barclay Queen Anne's Co</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>James Salloway</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Delabay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Margaret Lohs Catonsville Maryland</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## INTERVAL BETWEEN ONSET AND DEATH

442x Immediate cause	(a) <u>Myocardial Infarction</u>	5 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Chronic Hypertensive Cardio-Vascular-Renal Disease</u>	10 yrs.
(c)		

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2-16, 1953., to 11/7-, 1957., that I last saw the deceased alive on 11-7-, 1957., and that death occurred at 10:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	DATE THEREOF <u>Nov. 11-1957</u>	NAME OF CEMETERY OR CREMATORY <u>Chesapeake</u>	LOCATION (City, town, or county) <u>Catonsville</u>	(State) <u>Maryland</u>
DATE REC'D BY LOCAL REG. <u>11-11-57</u>	REGISTRAR'S SIGNATURE <u>Eliza J. [Signature]</u>	24. FUNERAL DIRECTOR <u>Wm. B. [Signature]</u>	ADDRESS <u>Catonsville</u>	

MARGIN RESERVED FOR BINING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 22 1957

BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

11478

CERTIFICATE OF DEATH

11525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>12 Patapsco Ave</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>53 Dundalk</i> d. STREET ADDRESS <i>1 12 Patapsco Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Marie</i> Middle <i>Cohn</i> Last <i>Cohn</i>		4. DATE OF DEATH Month <i>November</i> Day <i>15</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 13, 1864</i>
9. AGE (In years last birthday) <i>93</i>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>Germany</i>	
13. FATHER'S NAME <i>Riecken</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Harry Cohn - Glen Burnie, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio-sclerotic C. &amp; D</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/10</i> , 19 <i>57</i> , to <i>11/15</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11/15</i> , 19 <i>57</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel J. Harker</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>7 Patapsco Ave 11/15/57</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Nov 15/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Our Sinai</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sol Levinson &amp; Bros Inc</i> ADDRESS <i>-1124-26 W. North Avenue</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 18 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Wm. Kelly</i>	

CERTIFICATE OF DEATH

11175

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
JAMES H. HARRIS		M		45		W		Carpenter	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
Baltimore, Md.		Jan 15, 1892		Jan 18, 1957		10:30 AM		Heart Disease	
11. PLACE OF DEATH		12. DATE OF DEATH		13. TIME OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
Baltimore, Md.		Jan 18, 1957		10:30 AM		Heart Disease		Natural	
16. SIGNATURE OF PHYSICIAN		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF WITNESS		19. SIGNATURE OF DECEASED		20. SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

NOV 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11530 CERTIFICATE OF DEATH

11526

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>15 MINUTES</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>3 Vol-4</b>	
4. DATE OF DEATH First Middle Last <b>FRANKLIN COLLINS</b> Month Day Year <b>NOVEMBER 6 19 57</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 18, 1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HUCKSTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES H COLLINS</b>		14. MOTHER'S MAIDEN NAME <b>Lena Glace</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-1</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT Address <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>493X</b> IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>ARTERIOSCLEROTIC HEART DISEASE-CONGESTIVE FAILURE; DIABETES; OBESITY</b>			INTERVAL BETWEEN ONSET AND DEATH <b>72 HOURS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4:10 PM, NOV 6, 19 57</b> , to <b>4:25 PM, NOV 6, 19 57</b> , that I last saw the deceased alive on <b>NOV 6, 19 57</b> , and that death occurred at <b>4:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD MARYLAND</b> DATE SIGNED <b>11-6-57</b> ACTUAL SIGNATURE <b>Winston C Dudley</b> M.D. PHYSICIAN'S NAME (Type) <b>WINSTON C DUDLEY</b> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov. 11/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LILLY AND ZEILER INC 1901 EASTERN AVE BALTO MD</b>		24a. REC'D BY REGISTRAR <b>11/8/57</b> 24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farber</b>	





11531

CERTIFICATE OF DEATH

11527 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>B BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE (25) 0250.2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>109 HILLTOP ROAD</b>	
3. NAME OF DECEASED (Type or print) (Also <b>JAMES</b> first <b>A.</b> Middle <b>P.</b> Last <b>COLLINS</b> ) <b>COLLINS, SR.</b>		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1887</b>
9. AGE (In years last birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Claims Investigator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transit Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Patrick M. Collins</b>		14. MOTHER'S MAIDEN NAME <b>Mary Harrington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>214-20-8629</b>	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA, LEFT UPPER AND LOWER LOBES</b> <b>490X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PULMONARY EDEMA AND CONGESTION</b> DUE TO <b>AORTIC STENOSIS AND INSUFFICIENCY</b> (c) <b>UNKNOWN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 3, 1957</b> to <b>November 25, 1957</b> and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA HOSPITAL, FORT HOWARD, MARYLAND 11/26/57</b>			
ACTUAL SIGNATURE <b>Chien Wei Lan</b>		M.D. <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov-29-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. B. Winnert</b>		ADDRESS <b>Balto. &amp; Monroe Sts. Baltimore, Maryland</b>	
24a. REC'D BY REGISTRAR <b>11/29/57</b>		24b. REGISTRAR'S SIGNATURE <b>Lewis L. Taylor</b>	

BUREAU V. S.

DEC 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11532 CERTIFICATE OF DEATH

11528-44  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>7 DAYS</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				d. STREET ADDRESS <b>2757 BAKER STREET</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>S</b> Last <b>COLLINS</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>3</b> Year <b>rd, 19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 16, 1915</b>	
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTAL CLERK</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. POST OFFICE</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>SHELTON COLLINS</b>				14. MOTHER'S MAIDEN NAME <b>EMILY THOMAS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW-11</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOLOSCLEROSIS OF KIDNEYS AND PYELONEPHRITIS</b> (b) <b>PULMONARY CONGESTION AND EDEMA</b> (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>1 WEEK</b> <b>10 YEARS</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>BALTIMORE</b>				20g. (County) <b>BALTIMORE</b>		20h. (State) <b>MARYLAND</b>	
21. I certify that I attended the deceased from <b>OCTOBER 27, 19 57</b> , to <b>NOVEMBER 3, 19 57</b> . I am the physician who attended the deceased and that death occurred at <b>4:00 p.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD MARYLAND</b> DATE SIGNED <b>11/4/57</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William C March</b> ADDRESS <b>William C March Funeral Home 928 E North Ave/</b>				24a. REC'D BY REGISTRAR DATE <b>11/5/57</b>		24b. REGISTRAR'S SIGNATURE <b>Johnson L. Farley</b>	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARRIAGE		OCCUPATION		EDUCATION		RELIGION		MILITARY SERVICE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.	
JAMES EARL RAY		5-12-28		M		W		M		C		H		M		M		5-12-68		MEMPHIS, TENN		HEART DISEASE		NATURAL		100-100000		100-100000	
FATHER		MOTHER		SPOUSE		CHILDREN		SIBLINGS		PARENTS		GRANDPARENTS		OTHER RELATIVES		FRIENDS		CLERGY		MEDICAL ATTENDANT		PATHOLOGIST		CORONER		BURIAL		REMARKS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

NOV 6 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11529

Reg. Dist. No.

45

11533

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex 21</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10 Terrace Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex 21, Md. 54</u> d. STREET ADDRESS <u>10 Terrece Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Josephine</u> Middle <u>M.</u> Last <u>Cooper</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>4</u> Year <u>19 57</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>August 3, 1898</u>		<b>9. AGE</b> (In years last birthday) <u>59</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>James G. Bailey</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Julia Ober</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>Everett Cooper</u>				<b>Address</b> <u>Same</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>												INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> <u>  </u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <u>M. B. Davis</u> M.D.						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>EXAMINER'S NAME (Type)</b> <u>M. B. Davis M.D.</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>							
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>11/5/57</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>11/7/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Oaklawn Cemetery</u>				<b>22d. LOCATION (City, town, or county)</b> <u>Baltimore, Maryland</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>James J. Prudzik</u>						<b>ADDRESS</b> <u>1401 Eastern Ave.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>NOV 7 1957</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Edith Hurley</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
NOV 7 1957  
BUREAU V. 3

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

11534

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Cockeysville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Beaver Dam Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Coyle</i> Middle Last		4. DATE OF DEATH <i>November 25</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10 August 1882</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Manager</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Manufacturing</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore City Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Coyle</i>		14. MOTHER'S MAIDEN NAME <i>Araminta Wright</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-05-1671</i>	
17. INFORMANT <i>Sam</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple myeloma</i> <i>203x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>8 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug 1956</i> to <i>Nov 25</i> , that I last saw the deceased alive on <i>25 Nov 1957</i> , and that death occurred at <i>11:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D.		ADDRESS (Street, city or town, state) <i>Cockeysville, Md</i> DATE SIGNED <i>25 Nov 1957</i>	
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/29/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Balto., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>WM. J. TICKNER &amp; SONS</i>		ADDRESS <i>B.P.S. Balto. 17, Md.</i>	
24a. REC'D BY REGISTRAR <i>11/26/57</i>		24b. REGISTRAR'S SIGNATURE <i>A. H. H. druck</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED  
NOV 27 1957  
BUREAU V. S.

RECEIVED  
NOV 27 1957  
BUREAU V. S.

MADE IN U.S.A.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11533

Reg. Dist. No.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3425 OLD NORTH POINT ROAD</b>		d. STREET ADDRESS <b>3425 OLD NORTH POINT RD.</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas C. CROWLEY JR</b>		4. DATE OF DEATH Month <b>11</b> Day <b>-2</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/14/57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Baltimore</b>	
13. FATHER'S NAME <b>THOMAS CROWLEY</b>		14. MOTHER'S MAIDEN NAME <b>CARMEN SULLIVAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>THOMAS CROWLEY, 3425 Old North Pt. Rd</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7544 Congenital Heart Disease</b> DUE TO <b>AORTIC ATRESIA WITH</b> Conditions, if any, which gave rise to immediate cause (b) <b>COARCTATION</b> (c) <b>COARCTATION</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. S. FISHER</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. S. FISHER</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 4, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly + Zeiler Inc., 403 S. Wolfe St.</b>		24a. REG'D BY REGISTRAR <b>NOV 4 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>John Kelly</b>	

BUREAU V. S.

NOV 7 1957

RECEIVED



## 11535 CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>xo Glen Arm</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mr. Eugene</u> Middle <u>E.</u> Last <u>Dalton</u>		4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>F.X. Hooper Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Peter Dalton</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Lynch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Marie E. Dalton, Glen Arm, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CONCORDY INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/15</u> , 19 <u>57</u> , to <u>11/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/15</u> , 19 <u>57</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Fork, Md.</u> DATE SIGNED ACTUAL SIGNATURE <u>Clifford F. Hudson</u> PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON, FORK, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>NOV 19 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mr. Walter Hammett</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
NOV 19 1957  
BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO. 100

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH 11/13/57		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide		9. DISEASE OR INJURY None	
10. SIGNATURE OF DECEASED James Earl Ray		11. SIGNATURE OF WITNESS James Earl Ray		12. SIGNATURE OF PHYSICIAN James Earl Ray	
13. SIGNATURE OF CORONER James Earl Ray		14. SIGNATURE OF JURY James Earl Ray		15. SIGNATURE OF JUDGE James Earl Ray	
16. SIGNATURE OF DISTRICT ATTORNEY James Earl Ray		17. SIGNATURE OF SHERIFF James Earl Ray		18. SIGNATURE OF CLERK James Earl Ray	
19. SIGNATURE OF CHIEF OF POLICE James Earl Ray		20. SIGNATURE OF CHIEF OF FIRE DEPARTMENT James Earl Ray		21. SIGNATURE OF CHIEF OF PUBLIC WORKS James Earl Ray	
22. SIGNATURE OF CHIEF OF HEALTH DEPARTMENT James Earl Ray		23. SIGNATURE OF CHIEF OF SOCIAL SERVICES James Earl Ray		24. SIGNATURE OF CHIEF OF EDUCATION James Earl Ray	
25. SIGNATURE OF CHIEF OF LABOR RELATIONS James Earl Ray		26. SIGNATURE OF CHIEF OF HUMAN RESOURCES James Earl Ray		27. SIGNATURE OF CHIEF OF FINANCE James Earl Ray	
28. SIGNATURE OF CHIEF OF LEGAL COUNSEL James Earl Ray		29. SIGNATURE OF CHIEF OF OFFICE OF MANAGEMENT James Earl Ray		30. SIGNATURE OF CHIEF OF INFORMATION SYSTEMS James Earl Ray	
31. SIGNATURE OF CHIEF OF COMMUNICATIONS James Earl Ray		32. SIGNATURE OF CHIEF OF TRANSPORTATION James Earl Ray		33. SIGNATURE OF CHIEF OF UTILITIES James Earl Ray	
34. SIGNATURE OF CHIEF OF ENVIRONMENTAL PROTECTION James Earl Ray		35. SIGNATURE OF CHIEF OF OCCUPATIONAL SAFETY AND HEALTH James Earl Ray		36. SIGNATURE OF CHIEF OF CONSUMER PROTECTION James Earl Ray	
37. SIGNATURE OF CHIEF OF FEDERAL RESERVE James Earl Ray		38. SIGNATURE OF CHIEF OF SECURITIES AND EXCHANGE COMMISSION James Earl Ray		39. SIGNATURE OF CHIEF OF NATIONAL AERONAUTICS AND SPACE ADMINISTRATION James Earl Ray	
40. SIGNATURE OF CHIEF OF DEPARTMENT OF AGRICULTURE James Earl Ray		41. SIGNATURE OF CHIEF OF DEPARTMENT OF COMMERCE James Earl Ray		42. SIGNATURE OF CHIEF OF DEPARTMENT OF DEFENSE James Earl Ray	
43. SIGNATURE OF CHIEF OF DEPARTMENT OF EDUCATION James Earl Ray		44. SIGNATURE OF CHIEF OF DEPARTMENT OF ENERGY James Earl Ray		45. SIGNATURE OF CHIEF OF DEPARTMENT OF HEALTH AND HUMAN SERVICES James Earl Ray	
46. SIGNATURE OF CHIEF OF DEPARTMENT OF JUSTICE James Earl Ray		47. SIGNATURE OF CHIEF OF DEPARTMENT OF LABOR James Earl Ray		48. SIGNATURE OF CHIEF OF DEPARTMENT OF TRANSPORTATION James Earl Ray	
49. SIGNATURE OF CHIEF OF DEPARTMENT OF VETERANS AFFAIRS James Earl Ray		50. SIGNATURE OF CHIEF OF DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT James Earl Ray		51. SIGNATURE OF CHIEF OF DEPARTMENT OF INTERIOR James Earl Ray	
52. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY James Earl Ray		53. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY James Earl Ray		54. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE James Earl Ray	
55. SIGNATURE OF CHIEF OF DEPARTMENT OF THE COAST GUARD James Earl Ray		56. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS James Earl Ray		57. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray	
58. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray		59. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray		60. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray	
61. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray		62. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray		63. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray	
64. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray		65. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray		66. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray	
67. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray		68. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray		69. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray	
70. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray		71. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray		72. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray	
73. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray		74. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray		75. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray	
76. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray		77. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray		78. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray	
79. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray		80. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray		81. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray	
82. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray		83. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray		84. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray	
85. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray		86. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray		87. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray	
88. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray		89. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray		90. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray	
91. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray		92. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray		93. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray	
94. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray		95. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray		96. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray	
97. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray		98. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray		99. SIGNATURE OF CHIEF OF DEPARTMENT OF THE AIR FORCE AIRCRAFT James Earl Ray	
100. SIGNATURE OF CHIEF OF DEPARTMENT OF THE MARINE CORPS AIRCRAFT James Earl Ray		101. SIGNATURE OF CHIEF OF DEPARTMENT OF THE ARMY AIRCRAFT James Earl Ray		102. SIGNATURE OF CHIEF OF DEPARTMENT OF THE NAVY AIRCRAFT James Earl Ray	

11536

## CERTIFICATE OF DEATH

Reg. Dist. No.

## I. PLACE OF DEATH:

COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Middle River

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Baltim.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

XO Middle River

STREET ADDRESS

(If rural give location)

131 Dihedral Drive

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Bettina or Elizabeth Del Costello

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

11 22 1957

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNOER 24 HRS.

Female

White

SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):

Jan. 8 1885

72

yrs. Months Days Hours Min.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

Tailor-retired- Tailor Shop Campobasso

U.S.A.

## 13. FATHER'S NAME:

Domenico Conti

## 14. MOTHER'S MAIDEN NAME:

Rosa Comegna

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS: Son

216-05-8100 Mario Del Costello 131 Dihedral Drive

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause

(a) DUE TO

CEREBRAL ACCIDENT

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

DUE TO

(c)

ARTERIOSCLEROTIC CEREBRO-VASCULAR DISEASE

Interval Between Onset And Death

1 WK

5 YRS

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Mar. 1957, to Nov. 22, 1957, that I last saw the deceased

alive on Nov. 22, 1957, and that death occurred at 11:15 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Nov. 23, 1957

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

## 23. BURIAL CREMATION, (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Nov. 23, 1957

Edith Hurlburt

Frank DellaHore 322 S. High St.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 27 1957

BURKAU V. S.

11479

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>3509 Esther Place Balto.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1603 Leslie Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Cross</u> Last <u>Cross</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/1898</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Yates</u>		14. MOTHER'S MAIDEN NAME <u>Adda Hawthorn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>WM B. Cross</u>		Address <u>3509 Esther Place</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF STOMACH WITH</u> DUE TO <u>General Metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>57</u> , to <u>Nov. 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 12</u> , 19 <u>57</u> , and that death occurred at <u>10<sup>45</sup></u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M B Davis</u>		M.D. <u>6800 NORTON ST RD</u> DATE SIGNED <u>11/14/57</u>	
PHYSICIAN'S NAME (Type) <u>M. B. Davis MD</u>		<u>Dundalk - rr - Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/16/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Heruysma Orleans</u>		ADDRESS <u>2024</u>	
24a. REC'D BY REGISTRAR <u>Wm. M. Kelly, Jr.</u>		DATE <u>Nov 15 1957</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MAYLAND		M		25		1912		BALTIMORE		MD		USA			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
LABORER		HEART DISEASE		NATURAL		2 WEEKS		NOV 15 1937		BALTIMORE		MD		USA	
EDUCATION		SCHOOLING		RELIGION		MARRIAGE		PREVIOUS ILLNESS		DATE OF LAST ILLNESS		PLACE OF LAST ILLNESS		CITY	
HIGH SCHOOL		8 YEARS		METHODIST		MARRIED		NO		NOV 10 1937		BALTIMORE		MD	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
JOHN DOE		JANE DOE		LABORER		HOUSEWIFE		BALTIMORE		BALTIMORE		1908		1910	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF CHURCH CLERK		SIGNATURE OF BURIAL CLERK	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

NOV 15 1937

RECEIVED



11537

## CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale, Balto. 7, Md</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3401 Rolling Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>W. Edgar</b> Middle <b>Dell</b> Last				4. DATE OF DEATH Month <b>Nov</b> Day <b>21</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1902</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ref. &amp; Rsr Cont</b>		11. BIRTHPLACE (State or foreign country) <b>Merriottsville, Balto Co. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Jessie T. Dell</b>				14. MOTHER'S MAIDEN NAME <b>Bridget Hickey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-03-1957</b>		17. INFORMANT Address <b>Mrs. Agnes K. Dell 3401 Rolling Rd, Balto 7, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION -</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JUNE 1</b> , 1954, to <b>NOV. 21</b> , 1957, that I last saw the deceased alive on <b>NOV. 21</b> , 1957, and that death occurred at <b>7 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Thomas E. Wheeler M.D. 3601 Clifmar Rd - Balto 7 - 11/22/57</b>							
ACTUAL SIGNATURE <b>Thomas E. Wheeler</b>				PHYSICIAN'S NAME (Type) <b>THOMAS E. WHEELER 3601 CLIFMAR RD BALTO 7 - MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LORING WERS 5005 Park Heights Ave</b> <b>Balto 15, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>11/25/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. J. H. Masten</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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• **• • • • •**

VC

[illegible]

500 731 4 500

1102 T. J. O'Connell

weight: 105 lb

7261-70-415

\_\_\_\_\_

**BUREAU V. S.**

NOV 26 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11538

## CERTIFICATE OF DEATH

11536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOOD BROOK VILLAGE</b>		c. LENGTH OF STAY IN 1b <b>3 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6125 CHARLES ST. AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE W. DI PAULA</b>		4. DATE OF DEATH Month Day Year <b>NOV. 19 1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 12 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEA FOOD</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SALVATORE DI PAULA</b>		14. MOTHER'S MAIDEN NAME <b>ROSA D'AMTONI</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-32-3103</b>	
17. INFORMANT <b>MARGARET DI PAULA</b>		Address <b>6125 CHARLES ST. AVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial degeneration.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUG. 29<sup>th</sup></b> , 19 <b>56</b> , to <b>NOV. 19<sup>th</sup></b> , 19 <b>57</b> , that I last saw the deceased alive on <b>NOV. 19<sup>th</sup></b> , 19 <b>57</b> , and that death occurred at <b>6:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7112 BELAIR RD</b> DATE SIGNED <b>11/20/57</b>			
ACTUAL SIGNATURE <b>M. X. Quinn</b>		M.D. <b>1927 York Rd</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV 22-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE</b>		22d. LOCATION (City, town, or county) (State) <b>NORTH AVE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Bros</b>		24a. REC'D BY REGISTRAR <b>NOV 22 '57</b>	
ADDRESS <b>7110 BELAIR RD</b>		24b. REGISTRAR'S SIGNATURE <b>W. Quinn</b>	

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

NOV

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11539

## CERTIFICATE OF DEATH

11537 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8510 Old Harford Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Louis A. Dockman</u>		4. DATE OF DEATH Month Day Year <u>November 5th 19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Financier</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Dockman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Saunders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mr. John K. Dockman, 8510 Old Harford</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular disease</u> <u>177X</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>Carcinoma - prostate</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>about 1 yr.</u> <u>?</u> <u>about 2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1955</u> , to <u>Nov 5, 1957</u> , that I last saw the deceased alive on <u>Nov 4/57</u> , and that death occurred at <u>3:20 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter S. Niblett</u>		ADDRESS (Street, city or town, state) <u>4408 Loch Raven Blvd</u> DATE SIGNED <u>11/5/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Walter S. Niblett</u>		Baltimore, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>Nov 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. J. M. B. B. B.</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11538

11540

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>5yr6mth5dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Baltimore (28)</b>	
4. DATE OF DEATH First <b>Nellie</b> Middle <b>May</b> Last <b>Doll</b>		4. DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 4, 1876</b>
9. AGE (In years lost birthday) <b>81 1/2 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Whisner</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Whisner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterioscler. Cardio Vasc. Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, General. Severe</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 14, 1957</b> , to <b>11/15, 1957</b> , that I lost saw the deceased alive on <b>4/15, 1957</b> , and that death occurred at <b>9:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11/15/57</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/21/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS</b>		24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <b>BALTO. 17, Md.</b> <b>NOV 20 57</b>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

NOV 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11541

## CERTIFICATE OF DEATH

11539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Cockeysville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baltimore Co. Home</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>P</u> Last <u>Dornen</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 18, 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Dornen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Donnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Balto. Co Home Records - Cockeysville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>Arteriosclerotic cardiac vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 23</u> , 19 <u>57</u> , to <u>Nov 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 23</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Elizabeth B. Sherrill</u> M.D.		ADDRESS (Street, city or town, state) <u>Cockeysville, Md.</u> DATE SIGNED <u>11/24/57</u>	
PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill M.D.</u>		<u>Cockeysville Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>✓</u>	<u>Nov 24, 1957</u>	<u>Md. State Board of Anatomy</u>	<u>11-24-57</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brooks</u>		24a. REC'D BY REGISTRAR <u>W. J. Philcoat</u>	
ADDRESS <u>1022 York Rd. Towson Md.</u>		DATE	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1875, 1900, 1925, 1950, 1975, 2000, 2025, 2050, 2075, 2100, 2125, 2150, 2175, 2200, 2225, 2250, 2275, 2300, 2325, 2350, 2375, 2400, 2425, 2450, 2475, 2500, 2525, 2550, 2575, 2600, 2625, 2650, 2675, 2700, 2725, 2750, 2775, 2800, 2825, 2850, 2875, 2900, 2925, 2950, 2975, 3000, 3025, 3050, 3075, 3100, 3125, 3150, 3175, 3200, 3225, 3250, 3275, 3300, 3325, 3350, 3375, 3400, 3425, 3450, 3475, 3500, 3525, 3550, 3575, 3600, 3625, 3650, 3675, 3700, 3725, 3750, 3775, 3800, 3825, 3850, 3875, 3900, 3925, 3950, 3975, 4000, 4025, 4050, 4075, 4100, 4125, 4150, 4175, 4200, 4225, 4250, 4275, 4300, 4325, 4350, 4375, 4400, 4425, 4450, 4475, 4500, 4525, 4550, 4575, 4600, 4625, 4650, 4675, 4700, 4725, 4750, 4775, 4800, 4825, 4850, 4875, 4900, 4925, 4950, 4975, 5000, 5025, 5050, 5075, 5100, 5125, 5150, 5175, 5200, 5225, 5250, 5275, 5300, 5325, 5350, 5375, 5400, 5425, 5450, 5475, 5500, 5525, 5550, 5575, 5600, 5625, 5650, 5675, 5700, 5725, 5750, 5775, 5800, 5825, 5850, 5875, 5900, 5925, 5950, 5975, 6000, 6025, 6050, 6075, 6100, 6125, 6150, 6175, 6200, 6225, 6250, 6275, 6300, 6325, 6350, 6375, 6400, 6425, 6450, 6475, 6500, 6525, 6550, 6575, 6600, 6625, 6650, 6675, 6700, 6725, 6750, 6775, 6800, 6825, 6850, 6875, 6900, 6925, 6950, 6975, 7000, 7025, 7050, 7075, 7100, 7125, 7150, 7175, 7200, 7225, 7250, 7275, 7300, 7325, 7350, 7375, 7400, 7425, 7450, 7475, 7500, 7525, 7550, 7575, 7600, 7625, 7650, 7675, 7700, 7725, 7750, 7775, 7800, 7825, 7850, 7875, 7900, 7925, 7950, 7975, 8000, 8025, 8050, 8075, 8100, 8125, 8150, 8175, 8200, 8225, 8250, 8275, 8300, 8325, 8350, 8375, 8400, 8425, 8450, 8475, 8500, 8525, 8550, 8575, 8600, 8625, 8650, 8675, 8700, 8725, 8750, 8775, 8800, 8825, 8850, 8875, 8900, 8925, 8950, 8975, 9000, 9025, 9050, 9075, 9100, 9125, 9150, 9175, 9200, 9225, 9250, 9275, 9300, 9325, 9350, 9375, 9400, 9425, 9450, 9475, 9500, 9525, 9550, 9575, 9600, 9625, 9650, 9675, 9700, 9725, 9750, 9775, 9800, 9825, 9850, 9875, 9900, 9925, 9950, 9975, 10000, 10025, 10050, 10075, 10100, 10125, 10150, 10175, 10200, 10225, 10250, 10275, 10300, 10325, 10350, 10375, 10400, 10425, 10450, 10475, 10500, 10525, 10550, 10575, 10600, 10625, 10650, 10675, 10700, 10725, 10750, 10775, 10800, 10825, 10850, 10875, 10900, 10925, 10950, 10975, 11000, 11025, 11050, 11075, 11100, 11125, 11150, 11175, 11200, 11225, 11250, 11275, 11300, 11325, 11350, 11375, 11400, 11425, 11450, 11475, 11500, 11525, 11550, 11575, 11600, 11625, 11650, 11675, 11700, 11725, 11750, 11775, 11800, 11825, 11850, 11875, 11900, 11925, 11950, 11975, 12000, 12025, 12050, 12075, 12100, 12125, 12150, 12175, 12200, 12225, 12250, 12275, 12300, 12325, 12350, 12375, 12400, 12425, 12450, 12475, 12500, 12525, 12550, 12575, 12600, 12625, 12650, 12675, 12700, 12725, 12750, 12775, 12800, 12825, 12850, 12875, 12900, 12925, 12950, 12975, 13000, 13025, 13050, 13075, 13100, 13125, 13150, 13175, 13200, 13225, 13250, 13275, 13300, 13325, 13350, 13375, 13400, 13425, 13450, 13475, 13500, 13525, 13550, 13575, 13600, 13625, 13650, 13675, 13700, 13725, 13750, 13775, 13800, 13825, 13850, 13875, 13900, 13925, 13950, 13975, 14000, 14025, 14050, 14075, 14100, 14125, 14150, 14175, 14200, 14225, 14250, 14275, 14300, 14325, 14350, 14375, 14400, 14425, 14450, 14475, 14500, 14525, 14550, 14575, 14600, 14625, 14650, 14675, 14700, 14725, 14750, 14775, 14800, 14825, 14850, 14875, 14900, 14925, 14950, 14975, 15000, 15025, 15050, 15075, 15100, 15125, 15150, 15175, 15200, 15225, 15250, 15275, 15300, 15325, 15350, 15375, 15400, 15425, 15450, 15475, 15500, 15525, 15550, 15575, 15600, 15625, 15650, 15675, 15700, 15725, 15750, 15775, 15800, 15825, 15850, 15875, 15900, 15925, 15950, 15975, 16000, 16025, 16050, 16075, 16100, 16125, 16150, 16175, 16200, 16225, 16250, 16275, 16300, 16325, 16350, 16375, 16400, 16425, 16450, 16475, 16500, 16525, 16550, 16575, 16600, 16625, 16650, 16675, 16700, 16725, 16750, 16775, 16800, 16825, 16850, 16875, 16900, 16925, 16950, 16975, 17000, 17025, 17050, 17075, 17100, 17125, 17150, 17175, 17200, 17225, 17250, 17275, 17300, 17325, 17350, 17375, 17400, 17425, 17450, 17475, 17500, 17525, 17550, 17575, 17600

**BUREAU V. S.**

NOV 27 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11540

Items 13.11 Film 223 12-2-57 et

11542

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY</span>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="float: right;">✓</span> <u>Baltimore</u> <span style="float: right;">3401-4</span>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mercy Villa</u>				d. STREET ADDRESS <u>1508 Northwick Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Theresa</u> Middle <u>M.</u> Last <u>Dumler</u>				<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>15</u> Year <u>19 57</u>											
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 17, 1875</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Charles F. Nitsch</u>						14. MOTHER'S MAIDEN NAME <u>Josephine Fuerst</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				17. INFORMANT Address <u>Mrs. H. W. Adams 1508 Northwick Rd.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic cardio vascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>June 5</u> , 19 <u>57</u> , to <u>November 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>November 15</u> , 19 <u>57</u> , and that death occurred at <u>6:15 p.m.</u> , from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>Philip D. Flynn M.D.</u> M.D.						ADDRESS (Street, city or town, state) <u>11 East Chase Street #2</u>				DATE SIGNED <u>11/18/57</u>					
PHYSICIAN'S NAME (Type) <u>Philip D. Flynn M.D. (Philip D. Flynn, M.D.)</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville Md.</u>						ADDRESS		24a. REC'D BY REGISTRAR DATE <u>NOV 22 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Al. Lewis</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-100

PLACE IN DATE		MARRIAGE	
DATE OF DEATH		DATE OF MARRIAGE	
PLACE OF DEATH		PLACE OF MARRIAGE	
NAME OF DECEASED		NAME OF SPOUSE	
AGE		AGE	
SEX		SEX	
RACE		RACE	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF SPOUSE	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERK		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF NOTARY		SIGNATURE OF NOTARY	
SIGNATURE OF DECEASED		SIGNATURE OF SPOUSE	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CLERK		SIGNATURE OF CLERK	
SIGNATURE OF JUDGE		SIGNATURE OF JUDGE	
SIGNATURE OF NOTARY		SIGNATURE OF NOTARY	

BUREAU V. S.

NOV 22 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, pending the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11543 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11541  
43

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BALTIMORE</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 RURAL BALTIMORE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8903 Belair Rd.</b>				d. STREET ADDRESS <b>8903 Belair Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>H.</b> Last <b>DUNN</b>				4. DATE OF DEATH Month <b>NOV</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1884</b>		9. AGE (In years last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Packing Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Dunn</b>				14. MOTHER'S MAIDEN NAME <b>Georgia E. Duncan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>338-09-4980</b>		17. INFORMANT Address <b>Mrs. Mary E. Riley 8903 Belair Rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY ARTERY DISEASE</b> DUE TO (c) <b>Generalized Athersclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>inst</b> <b>lyr approx</b> <b>undet</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John C. Hyle</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JOHN C HYLE</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 29, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassah Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR <b>NOV 29 1957</b>	
						24b. REGISTRAR'S SIGNATURE <b>Mrs. A. L. Ruffin</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		DATE	

**RECEIVED**  
 NOV 29 1957  
**BUREAU V. S.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11544

CERTIFICATE OF DEATH

11542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr11mth23dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Winifred</b> Middle <b>Cecelia</b> Last <b>Dunne</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 25, 1873</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Ireland</b>							
13. FATHER'S NAME <b>William Burns</b>				14. MOTHER'S MAIDEN NAME <b>Mary Kilmurray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 15</b> , 19 <b>57</b> , to <b>Nov. 18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 18</b> , 19 <b>57</b> , and that death occurred at <b>8:15 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11-18-57</b> ACTUAL SIGNATURE <b>Stella Wachsler</b> M.D. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M.D.</b> <b>Catonsville 28, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Nov. 21/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Texas, Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Bruno</b>				24a. REC'D BY REGISTRAR <b>Nov 20 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Overhach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 20 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11545

## CERTIFICATE OF DEATH

11543

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>L</u> Last <u>DURNER</u>		4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 17, 1897</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Box Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse B. Durner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bollinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>218-10-1167</u>	
17. INFORMANT <u>Clin. Rec., Vets. Adm. Hospital, Ft. Howard, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, BRONCHITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR AND RENAL DISEASE</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>va</u> attended the deceased from <u>November 8</u> , 19 <u>57</u> , to <u>November 13</u> , 19 <u>57</u> , that <u>va</u> was the deceased's <u>live in</u> and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chien Wei Ian</u>		M.D. <u>VAH Ft. Howard, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>CHIENT WEI IAN, M.D.</u>		<u>11/14/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Darlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank W. Seitz</u>		ADDRESS <u>811 W. 36th St. Balto. Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 18 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Fenty</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
 SEX: [illegible] AGE: [illegible]  
 DATE OF BIRTH: [illegible]  
 PLACE OF BIRTH: [illegible]  
 OCCUPATION: [illegible]  
 CAUSE OF DEATH: [illegible]  
 PLACE OF DEATH: [illegible]  
 DATE OF DEATH: [illegible]  
 TIME OF DEATH: [illegible]  
 SIGNATURE OF PHYSICIAN: [illegible]  
 SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. S.

NOV 18 1957

RECEIVED



11546

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>				c. LENGTH OF STAY IN 1b <u>78 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>259 Rodgers Forge Road</u>				d. STREET ADDRESS <u>259 Rodgers Forge Road</u>			
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>P</u> Last <u>DUVALL</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1, 1879</u>	
9. AGE (In years last birthday) <u>78 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>C. A. Wilson &amp; Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u></u>							
13. FATHER'S NAME <u>Ridgely Duvall</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Howard Post</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Walter Post Duvall</u>	
				Address <u>259 Rodgers Forge Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>year</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>56</u> , to <u>Nov 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>57</u> , and that death occurred at <u>5:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Haverly S. Green, Jr.</u> M.D. <u>Pikesville 8, Md.</u>				DATE SIGNED <u>Nov 4, 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Meeks &amp; Son</u>				ADDRESS <u>805 N. Calvert St.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 6 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert Gray</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. EDUCATION [Faint text]		9. RELIGION [Faint text]		10. RACE [Faint text]	
11. CAUSE OF DEATH [Faint text]		12. MANNER OF DEATH [Faint text]		13. PLACE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]		15. SIGNATURE OF DECEASED [Faint text]	
16. SIGNATURE OF WITNESS [Faint text]		17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF DECEASED [Faint text]		19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF DECEASED [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF DECEASED [Faint text]		25. SIGNATURE OF DECEASED [Faint text]	
26. SIGNATURE OF DECEASED [Faint text]		27. SIGNATURE OF DECEASED [Faint text]		28. SIGNATURE OF DECEASED [Faint text]		29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF DECEASED [Faint text]		33. SIGNATURE OF DECEASED [Faint text]		34. SIGNATURE OF DECEASED [Faint text]		35. SIGNATURE OF DECEASED [Faint text]	
36. SIGNATURE OF DECEASED [Faint text]		37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF DECEASED [Faint text]		39. SIGNATURE OF DECEASED [Faint text]		40. SIGNATURE OF DECEASED [Faint text]	
41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF DECEASED [Faint text]		43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF DECEASED [Faint text]		45. SIGNATURE OF DECEASED [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF DECEASED [Faint text]		49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF DECEASED [Faint text]	
51. SIGNATURE OF DECEASED [Faint text]		52. SIGNATURE OF DECEASED [Faint text]		53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF DECEASED [Faint text]		55. SIGNATURE OF DECEASED [Faint text]	
56. SIGNATURE OF DECEASED [Faint text]		57. SIGNATURE OF DECEASED [Faint text]		58. SIGNATURE OF DECEASED [Faint text]		59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF DECEASED [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF DECEASED [Faint text]		63. SIGNATURE OF DECEASED [Faint text]		64. SIGNATURE OF DECEASED [Faint text]		65. SIGNATURE OF DECEASED [Faint text]	
66. SIGNATURE OF DECEASED [Faint text]		67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF DECEASED [Faint text]		69. SIGNATURE OF DECEASED [Faint text]		70. SIGNATURE OF DECEASED [Faint text]	
71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF DECEASED [Faint text]		73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF DECEASED [Faint text]		75. SIGNATURE OF DECEASED [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF DECEASED [Faint text]		79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF DECEASED [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF DECEASED [Faint text]		83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF DECEASED [Faint text]		85. SIGNATURE OF DECEASED [Faint text]	
86. SIGNATURE OF DECEASED [Faint text]		87. SIGNATURE OF DECEASED [Faint text]		88. SIGNATURE OF DECEASED [Faint text]		89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF DECEASED [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF DECEASED [Faint text]		93. SIGNATURE OF DECEASED [Faint text]		94. SIGNATURE OF DECEASED [Faint text]		95. SIGNATURE OF DECEASED [Faint text]	
96. SIGNATURE OF DECEASED [Faint text]		97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF DECEASED [Faint text]		99. SIGNATURE OF DECEASED [Faint text]		100. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. 1

NOV 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11545

11488

CERTIFICATE OF DEATH

Reg. Dist. No.

42

1. NAME OF DECEASED  
(Type or Print)

Edward P. Egan, Sr.

2. DATE  
OF  
DEATH

Nov. 10, 1957

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street address or location)  
5214 Benson Ave  
Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
5214 Benson Avenue - Baltimore

D. STREET ADDRESS (If rural, give location)

5214 Benson Ave.

c. Length of stay in Baltimore

Life

5. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

Feb. 6, 1873

9. AGE (In years  
last birthday)

84 Yrs

10 Under 1 Year  
Months: Days

11 Under 24 Hours  
Hours: Min.

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Plumber

10B. KIND OF BUSINESS OR  
INDUSTRY

Self-Emp.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Edward B. Egan

14. MOTHER'S MAIDEN NAME

Ellen Lyon

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

Edward P. Egan, Jr. 5214 Benson Ave.

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e. g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Myocardial Infarction

INTERVAL BETWEEN  
ONSET AND DEATH

Sudden

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio-  
Vascular Disease

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II  
21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED.

20. AUTOPSY?  
YES ☒ NO ☐

21E. INJURY OCCURRED  
WHILE AT ☐ WORK NOT WHILE ☐  
AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2/1 1957 to 11/10 1957, that (I) (we) last saw the deceased alive on 11/7 1957, and that death occurred at 9:30 a.m. from the causes and on the date stated above.

23A. SIGNATURE

W. Frederick

23B. ADDRESS

205 Francis Ave.

23C. DATE SIGNED

11/11/57

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

11/13/57

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery Baltimore, Maryland

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY  
LOCAL REGISTRAR

11/12/57

REGISTRAR'S SIGNATURE

Dr. Geo. M. Kieffer

25. FUNERAL DIRECTOR

John A. Moran-3000 E. Baltimore St.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information so carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED  
NOV 14 1957  
BUREAU W. E.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11547

## CERTIFICATE OF DEATH

11546

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>		d. STREET ADDRESS <b>639 Aldershot Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>639 Aldershot Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>H.</b> Last <b>EDGAR</b>		4. DATE OF DEATH Month <b>November</b> Day <b>16</b> , Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1881.</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Wesley Edgar</b>		14. MOTHER'S MAIDEN NAME <b>Mary Anna Waters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Mrs. Walter A. Edgar, Ellicott City, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 446x DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>Chronic Nephritis</b> DUE TO <b>Arterio Sclerosis.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>4 yrs.</b> <b>4 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 11, 1957</b> to <b>Nov. 16, 1957</b> , that I last saw the deceased alive on <b>Nov. 11, 1957</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Geo. E. Wells</b>		ADDRESS (Street, city or town, state) <b>4100 Edmondson Ave</b>	
PHYSICIAN'S NAME (Type) <b>GEO. E. WELLS</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 19, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons, Catonsville 28, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 19 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>Reese</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORICAL DATA	
PREVIOUS ILLNESS		TREATMENT		HOSPITAL		PHYSICIAN		NURSE		BURIAL		FUNERAL		OTHER DATA	

BUREAU V. S.  
NOV 19 1957

RECEIVED

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	MANNER OF DEATH	MEDICAL HISTORY	HISTORICAL DATA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11548

## CERTIFICATE OF DEATH

11547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>5mths7dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ANNA</b> Last <b>EDLER</b>				4. DATE OF DEATH Month <b>11</b> Day <b>3</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 2, 1874</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Ludwig Edler</b>				14. MOTHER'S MAIDEN NAME <b>Teresa RABEL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>215-05-9671</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic glomerulonephritis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cellulitis left arm</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct. 15</b> , 19 <b>57</b> to <b>11/3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/3</b> , 19 <b>57</b> , and that death occurred at <b>10:55 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b>							
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b> <b>Catonsville 28, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-6-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Louisa Park</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George L. Schwaab</b> ADDRESS <b>2101 Frederick Ave</b>				24a. REC'D BY REGISTRAR <b>NOV 6 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Quinn</b>	

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		Male		35		White		1922		Memphis, Tenn.		April 4, 1968		London, England		Gunshot wound		Suicide		[Signature]		[Signature]	
13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. SOCIAL SECURITY NUMBER		18. MEDICAL HISTORY		19. PRESENT ILLNESS		20. POST-MORTEM EXAMINATION		21. TOXICOLOGICAL EXAMINATION		22. OTHER INFORMATION		23. SIGNATURE OF WITNESSES		24. SIGNATURE OF CORONER	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	

BUREAU V. 2

NOV 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11489 CERTIFICATE OF DEATH

11548 ✓

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Halethorpe</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2011 Northeast Avenue</b>		d. STREET ADDRESS <b>2011 Northeast Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNE</b> Middle <b>MADORA</b> Last <b>EDWARDS</b>		4. DATE OF DEATH Month <b>11</b> Day <b>30</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1862</b>
9. AGE (In years last birthday) <b>95</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland; Calvert County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Edlen</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Edlen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <b>Mrs. Harry Collick</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Mitral Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>11 months</b>  <b>?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 1, 57</b> , 19____, to <b>Nov. 30, 57</b> , 19____, that I last saw the deceased alive on <b>11.30.57</b> , 19____, and that death occurred at <b>7.00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Winters Lane</b> DATE SIGNED <b>11/30/57</b>			
ACTUAL SIGNATURE <b>C. F. Maloney M.D.</b>		M.D. <b>57 Winters Lane</b>	
PHYSICIAN'S NAME (Type) <b>C. F. Maloney, M.D.</b>		<b>Catonsville, 28, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 4, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Auburn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ELROY O. WILSON</b>		ADDRESS <b>1000 Brant ley Avenue</b>	
24a. REC'D BY REGISTRAR <b>DEC 9 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Leo M. Kupper</b>	

BUREAU V. S.

DEC 9 1957

RECEIVED

11549

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>House in the Pines</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto.</b> <b>3Y01.4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Fusting Ave.</b>				d. STREET ADDRESS <b>formerly of 2715 Gwynns Falls Pkwy</b>			
3. NAME OF DECEASED (Type or print) First <b>Henrietta</b> Middle <b>Einstein</b> Last				4. DATE OF DEATH Month <b>Nov.</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 3, 1859</b>		9. AGE (In years last birthday) <b>97</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>Samuel Einstein</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mr. Robert S. Einstein - 3700 N. Charles St.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Dysfunction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr. Hypertensive Cardio-Vascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b> <b>20 yr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-8</b> , 19 <b>51</b> , to <b>11-15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-15</b> , 19 <b>57</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore 28, Md.</b> DATE SIGNED <b>11-16-57</b>							
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>				M.D. <b>6209 Frederick Ave</b>			
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>				<b>Baltimore 28, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Har Sinai</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS</b>				ADDRESS <b>Balto. 17, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 18 57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Quel...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1957

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>		<p>3. AGE [Faint text]</p>	
<p>4. DATE OF DEATH [Faint text]</p>		<p>5. PLACE OF DEATH [Faint text]</p>		<p>6. CAUSE OF DEATH [Faint text]</p>	
<p>7. MANNER OF DEATH [Faint text]</p>		<p>8. SIGNATURE OF DECEASED [Faint text]</p>		<p>9. SIGNATURE OF WITNESS [Faint text]</p>	
<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>11. SIGNATURE OF CORONER [Faint text]</p>		<p>12. SIGNATURE OF JURY [Faint text]</p>	
<p>13. SIGNATURE OF DECEASED [Faint text]</p>		<p>14. SIGNATURE OF WITNESS [Faint text]</p>		<p>15. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>16. SIGNATURE OF CORONER [Faint text]</p>		<p>17. SIGNATURE OF JURY [Faint text]</p>		<p>18. SIGNATURE OF DECEASED [Faint text]</p>	
<p>19. SIGNATURE OF WITNESS [Faint text]</p>		<p>20. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>21. SIGNATURE OF CORONER [Faint text]</p>	
<p>22. SIGNATURE OF JURY [Faint text]</p>		<p>23. SIGNATURE OF DECEASED [Faint text]</p>		<p>24. SIGNATURE OF WITNESS [Faint text]</p>	
<p>25. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>26. SIGNATURE OF CORONER [Faint text]</p>		<p>27. SIGNATURE OF JURY [Faint text]</p>	
<p>28. SIGNATURE OF DECEASED [Faint text]</p>		<p>29. SIGNATURE OF WITNESS [Faint text]</p>		<p>30. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>31. SIGNATURE OF CORONER [Faint text]</p>		<p>32. SIGNATURE OF JURY [Faint text]</p>		<p>33. SIGNATURE OF DECEASED [Faint text]</p>	
<p>34. SIGNATURE OF WITNESS [Faint text]</p>		<p>35. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>36. SIGNATURE OF CORONER [Faint text]</p>	
<p>37. SIGNATURE OF JURY [Faint text]</p>		<p>38. SIGNATURE OF DECEASED [Faint text]</p>		<p>39. SIGNATURE OF WITNESS [Faint text]</p>	
<p>40. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>41. SIGNATURE OF CORONER [Faint text]</p>		<p>42. SIGNATURE OF JURY [Faint text]</p>	
<p>43. SIGNATURE OF DECEASED [Faint text]</p>		<p>44. SIGNATURE OF WITNESS [Faint text]</p>		<p>45. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>46. SIGNATURE OF CORONER [Faint text]</p>		<p>47. SIGNATURE OF JURY [Faint text]</p>		<p>48. SIGNATURE OF DECEASED [Faint text]</p>	
<p>49. SIGNATURE OF WITNESS [Faint text]</p>		<p>50. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>51. SIGNATURE OF CORONER [Faint text]</p>	
<p>52. SIGNATURE OF JURY [Faint text]</p>		<p>53. SIGNATURE OF DECEASED [Faint text]</p>		<p>54. SIGNATURE OF WITNESS [Faint text]</p>	
<p>55. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>56. SIGNATURE OF CORONER [Faint text]</p>		<p>57. SIGNATURE OF JURY [Faint text]</p>	
<p>58. SIGNATURE OF DECEASED [Faint text]</p>		<p>59. SIGNATURE OF WITNESS [Faint text]</p>		<p>60. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>61. SIGNATURE OF CORONER [Faint text]</p>		<p>62. SIGNATURE OF JURY [Faint text]</p>		<p>63. SIGNATURE OF DECEASED [Faint text]</p>	
<p>64. SIGNATURE OF WITNESS [Faint text]</p>		<p>65. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>66. SIGNATURE OF CORONER [Faint text]</p>	
<p>67. SIGNATURE OF JURY [Faint text]</p>		<p>68. SIGNATURE OF DECEASED [Faint text]</p>		<p>69. SIGNATURE OF WITNESS [Faint text]</p>	
<p>70. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>71. SIGNATURE OF CORONER [Faint text]</p>		<p>72. SIGNATURE OF JURY [Faint text]</p>	
<p>73. SIGNATURE OF DECEASED [Faint text]</p>		<p>74. SIGNATURE OF WITNESS [Faint text]</p>		<p>75. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>76. SIGNATURE OF CORONER [Faint text]</p>		<p>77. SIGNATURE OF JURY [Faint text]</p>		<p>78. SIGNATURE OF DECEASED [Faint text]</p>	
<p>79. SIGNATURE OF WITNESS [Faint text]</p>		<p>80. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>81. SIGNATURE OF CORONER [Faint text]</p>	
<p>82. SIGNATURE OF JURY [Faint text]</p>		<p>83. SIGNATURE OF DECEASED [Faint text]</p>		<p>84. SIGNATURE OF WITNESS [Faint text]</p>	
<p>85. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>86. SIGNATURE OF CORONER [Faint text]</p>		<p>87. SIGNATURE OF JURY [Faint text]</p>	
<p>88. SIGNATURE OF DECEASED [Faint text]</p>		<p>89. SIGNATURE OF WITNESS [Faint text]</p>		<p>90. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>91. SIGNATURE OF CORONER [Faint text]</p>		<p>92. SIGNATURE OF JURY [Faint text]</p>		<p>93. SIGNATURE OF DECEASED [Faint text]</p>	
<p>94. SIGNATURE OF WITNESS [Faint text]</p>		<p>95. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>96. SIGNATURE OF CORONER [Faint text]</p>	
<p>97. SIGNATURE OF JURY [Faint text]</p>		<p>98. SIGNATURE OF DECEASED [Faint text]</p>		<p>99. SIGNATURE OF WITNESS [Faint text]</p>	
<p>100. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>101. SIGNATURE OF CORONER [Faint text]</p>		<p>102. SIGNATURE OF JURY [Faint text]</p>	

BUREAU V. S.

NOV 19 1957

RECEIVED



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11550

1155039

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sparks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sparks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cold Bottom Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alexander Raymond Ensor</u>		4. DATE OF DEATH <u>Nov. 3 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>13</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTH PLACE (State or foreign country) <u>Balta Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Ensor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Gorsuch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Raymond Ensor</u>		Address <u>Sparks Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>C. M. France</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 6, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Black Rock Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Butler Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kastenstem</u>		24a. REC'D BY REGISTRAR <u>Nov 6 1957</u>	
ADDRESS <u>New Freedom Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>E. J. Gorsuch</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
NOV 6 1957  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11551 *4*

## 11490 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>				c. LENGTH OF STAY IN 1b <b>2 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5710 Mineral Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary A. Faulkner</b>				4. DATE OF DEATH Month Day Year <b>11 15 19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 7, 1871</b>	
9. AGE (In years last birthday) <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Vada Brown 5710 Mineral Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive A. S. CVD.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/1</b> 19 <b>57</b> , to <b>11/15</b> 19 <b>57</b> , that I last saw the deceased alive on <b>11/13</b> 19 <b>57</b> , and that death occurred at <b>7:30</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>John E. Kealey</b> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/17/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mount View</b>		22d. LOCATION (City, town, or county) (State) <b>Richwood, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrose, Inc. 1328 Sulphur Spring Rd.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Gov. M. Kupper</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 1117

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

REPLACEMENT CERT. 11/29/57  
MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11552

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Creek c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ketchum Lane		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Jones Creek d. STREET ADDRESS 1 Ketchum Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN LEROY FORNWALT		4. DATE OF DEATH Nov. 18, 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1900
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Fornwalt		14. MOTHER'S MAIDEN NAME Don't know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-20-2384	
17. INFORMANT Mrs. Gladys Fornwalt		Address Ketchum Lane.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1957	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk, Ave.		24a. REC'D BY REGISTRAR DATE 11/21/57	
		24b. REGISTRAR'S SIGNATURE A. H. Hedrich	

MEDICAL CERTIFICATION





11552

## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>129 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>903 E. Arlington Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>B.</b> Last <b>FOSTER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/8/95</b>	
				9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Private Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Thomas E. Foster</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Mason</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WWI</b>				16. SOCIAL SECURITY NO. <b>219-20-5563</b>		17. INFORMANT Address <b>Clin. Recs. Vets. Admin. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>541.0</b> <b>INTESTINAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC DUODENAL ULCER</b> DUE TO (c) <b>UNKNOWN</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>11/2/57 - Exploratory Laparotomy</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 12</b> , 19 <b>57</b> , to <b>November 18</b> , 19 <b>57</b> , that he was the deceased and that death occurred at <b>9:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>11/19/57</b>							
ACTUAL SIGNATURE <b>Chien Wei-Lan</b>				M.D. <b>Veterans Administration Hospital</b>			
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>				Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-22-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	
						22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary</b>				ADDRESS <b>802 Old Madison Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. D. L. Farber</b>	

MEDICAL CERTIFICATION

OR ATTENDING PHYSICIAN: The law requires that the certificate be executed within 72 hours after death. Page 4 may be filed by the funeral director, and completely filled out by the funeral director. Pages 5 and 6 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

NOV 22 1957

RECEIVED

1

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12

VS A15 (4)  
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11553

11554

Reg. Dist. No.

11553

CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY **BALTIMORE** MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE **MARYLAND** b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **COCKEYSVILLE** c. LENGTH OF STAY IN 1b **5 YEARS-10 MO.** c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **BALTIMORE** **3V01-4**

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION **MASONIC HOME** d. STREET ADDRESS **2122 BROOKFIELD AVE** e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **LEO** First **FREUDENTHAL** Middle **LOST** 4. DATE OF DEATH **NOV** Month **4** Day **1957** Year

5. SEX **MALE** 6. COLOR OR RACE **W** 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH **8-8-1881** 9. AGE (In years last birthday) **76** yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **CLERK** 10b. KIND OF BUSINESS OR INDUSTRY **CLOTHING** 11. BIRTHPLACE (State or foreign country) **GERMANY** 12. CITIZEN OF WHAT COUNTRY? **U. S.**

13. FATHER'S NAME **LOEB FREUDENTHAL** 14. MOTHER'S MAIDEN NAME **JOHANNA HIRSCH**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) **NO** (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. **220-03-2106** 17. INFORMANT **Frank L. Smith Jr. - Cockeysville Md.** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Cerebral Vascular Accident**  
**443x** DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Hypertensive Chronic Arteriosclerosis**  
DUE TO **Cardio Vascular Disease** (c)  
INTERVAL BETWEEN ONSET AND DEATH **2 years.**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 **11-7-57** 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **11-11-52**, 19 **11-4**, 19 **57**, that I last saw the deceased alive on **11-7-57**, and that death occurred at **10:22 AM**, from the causes and on the date stated above.  
ADDRESS (Street, city or town, state) **Cockeysville, Md.** DATE SIGNED

ACTUAL SIGNATURE **William Cook, Inc.** M.D. **William Cook, Inc.**

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **11-7-57** 22c. NAME OF CEMETERY OR CREMATORY **Baltimore Hebrew Cemetery** 22d. LOCATION (City, town, or county) (State) **Baltimore**

23. FUNERAL DIRECTOR'S SIGNATURE **William Cook, Inc., 1217 St. Paul Street** ADDRESS 24a. REC'D BY REGISTRAR **NOV 6 '57** 24b. REGISTRAR'S SIGNATURE **W. Leach**

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint handwritten name]</p>		<p>2. SEX                  [Faint handwritten sex]</p>	
<p>3. AGE                  [Faint handwritten age]</p>		<p>4. RACE                  [Faint handwritten race]</p>	
<p>5. DATE OF BIRTH                  [Faint handwritten date]</p>		<p>6. PLACE OF BIRTH                  [Faint handwritten place]</p>	
<p>7. DATE OF DEATH                  [Faint handwritten date]</p>		<p>8. PLACE OF DEATH                  [Faint handwritten place]</p>	
<p>9. CAUSE OF DEATH                  [Faint handwritten cause]</p>		<p>10. MANNER OF DEATH                  [Faint handwritten manner]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [Faint handwritten signature]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Faint handwritten signature]</p>	

BUREAU V. S.

NOV 6 1957

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11555

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>10 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines Nursing H.</u>		d. STREET ADDRESS <u>Latrobe Apartments</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>H.</u> Last <u>Funk</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Edw. B. Bruce &amp; Co. Liquor Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Funkstown, Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Peter S. Funk</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Hughes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>If yes, give war or dates of service</u>		17. INFORMANT <u>Miss Eliza Coale Funk Latrobe Apts.</u>	
16. SOCIAL SECURITY NO.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Cerebrovascular accident</u> <u>422.1</u> IMMEDIATE CAUSE (a) DUE TO <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>27 March</u> , 19 <u>55</u> to <u>10 November</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10 November</u> , 19 <u>57</u> , and that death occurred at <u>10:10 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>12 Nov, 1957</u>			
ACTUAL SIGNATURE <u>J. Douglas Lockard</u> M.D.			
PHYSICIAN'S NAME (Type) <u>J. Douglas Lockard</u> M.D.		<u>802 Cathedral Street, Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Meeks</u> ADDRESS <u>805 N. Calvert St</u>		24a. REC'D BY REGISTRAR <u>Nov 13 57</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. W. Meeks</u>	



BUREAU V. S.

NOV 3 1957

RECEIVED



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11556  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11555

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville (rural)</b> c. LENGTH OF STAY IN 1b <b>Johnnycake Road</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Johnnycake Road</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>Church Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MILDRED DULANY GASSAWAY</b>		4. DATE OF DEATH Month Day Year <b>Nov 16 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1907</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Iatrobe, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>?</b>	
13. FATHER'S NAME <b>Robert R. Piper</b>		14. MOTHER'S MAIDEN NAME <b>Bernadette ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Dr. Wm. N. Gassaway, Ellicott City, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>973.1</b> DUE TO <b>Carbon Monoxide Poison</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Suicide</b> DUE TO (c) <b>Suicide</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Found in auto in woods. horn attached to exhaust</b>	
20c. TIME OF INJURY Month, Day, Year <b>Nov 16 1957</b> Hour o. m. <b>9-30 p. m.</b>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>	20f. CITY or town (County) (State) <b>Baltimore</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>GEO. S. M. KIEFFER</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Balto, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. C. Higinbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR <b>Nov 20 57</b>	
24b. REGISTRAR'S SIGNATURE <b>Nov. 17, 57</b>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11555

BUREAU V. 3

NOV 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11557.44

Reg. Dist. No.

11556

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO SPARROWS POINT</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX 326 ROUTE 19</u>				d. STREET ADDRESS <u>BOX 326 ROUTE 19</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DESSIE MARY GINTLING</u>				4. DATE OF DEATH Month Day Year <u>NOV. 29 1957</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 24-1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FAIRFIELD - PA.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>HARRY LAWRENCE</u>				14. MOTHER'S MAIDEN NAME <u>MAY FOX</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>ROGER GINTLING BALDWIN - MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extradural Hematoma.</u> <u>904.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ankio - sclerosis - generalized</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>It fell in house - struck head.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>2 NOV 1957</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home.</u>	
				20f. (City or town) (County) (State) <u>Todd's Farm Balt Md.</u>			
21. I certify that I attended the deceased from <u>11-22</u> , 19 <u>57</u> , to <u>11-29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-28-57</u> , 19 <u>57</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>520 DPT Sp R 19 12-25</u>			
PHYSICIAN'S NAME (Type) <u>ROGER G WINDSOR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. ALDOUSIOUS</u>		22d. LOCATION (City, town, or county) (State) <u>LITTLESTOWN PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J Connelly</u> ADDRESS <u>Essex 21, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE DEC 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

HABITATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

HABITATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

HABITATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

HABITATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

HABITATION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

HABITATION

BUREAU V. S.

DEC 6 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

11557

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>5 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1718 Yakona Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rowan</b> Middle <b>Robert</b> Last <b>Glunt</b>		4. DATE OF DEATH Nov. 24, 1957		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 4, 1876</b>		9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months <b>10</b> Days <b>21</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired RR Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Glunt</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Aurandt</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>R.A.# 717-01-2464</b>		17. INFORMANT Address <b>Mrs. William T. Childs 6305 Charles St. Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized atherosclerotic C.V. disease</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> Month <b></b> Day <b>19</b> Year <b></b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/15</b> , 19 <b>57</b> , to <b>11/24</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/24</b> , 19 <b>57</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gordon Grau</b>		M.D. <b>2543 Jock Rowan Bldg</b>		ADDRESS (Street, city or town, state) <b>Baltimore Maryland</b>		DATE SIGNED <b>11/25/57</b>	
PHYSICIAN'S NAME (Type) <b>Gordon Grau</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc 1050 N. York Rd</b>				24a. REC'D BY REGISTRAR DATE <b>11/26/57</b>		24b. REGISTRAR'S SIGNATURE <b>Matel Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

Page One, No.

NAME OF DECEASED JAMES H. HARRIS		DATE OF BIRTH JAN 15 1895	
RESIDENCE 1234 E. BALTIMORE AVE.		CITY BALTIMORE	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH NOV 27 1957		PLACE OF DEATH HOME	
SEX MALE		RACE WHITE	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL	
RELIGION METHODIST		BLOOD TYPE O	
PREVIOUS ILLNESS NONE		TREATMENT NONE	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	

BUREAU V. S.

NOV 27 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11558

## CERTIFICATE OF DEATH

Reg. Dist. No.

1155932

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson</b>				c. LENGTH OF STAY IN 1b <b>xo Stevenson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Valley Road</b>				d. STREET ADDRESS <b>Valley Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>YERBURY</b> Last <b>GOLDSBOROUGH</b>				4. DATE OF DEATH Month <b>11</b> Day <b>19</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/5/1888</b>		9. AGE (In years last birthday) yrs. <b>69</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Paul Goldsborough</b>				14. MOTHER'S MAIDEN NAME <b>Helena McManus</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		(If yes, give war or dates of service) <b>World War I</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Mr. William B. Eppler - Stevenson, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> <b>Arteriosclerotic Cardiac Vascular Disease</b> DUE TO <b>Pulmonary emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary emphysema</b> DUE TO (c) <b>Pulmonary emphysema</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January, 1950</b> to <b>November 19, 1957</b> that I last saw the deceased alive on <b>November 13, 1957</b> , and that death occurred at <b>7 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>401 Medical Arts Bldg. - #1</b> DATE SIGNED <b>11/20/57</b>							
ACTUAL SIGNATURE <b>John R. Davis</b> M.D.				PHYSICIAN'S NAME (Type) <b>John R. Davis, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tuckner &amp; Sons</b>				24a. REC'D BY REGISTRAR <b>11/25/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
PRESENT ILLNESS [Faint text]		PREVIOUS ILLNESSES [Faint text]		SURVIVAL OF SURVIVORS [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]	

**RECEIVED**  
 NOV 26 1957  
**BUREAU V. S.**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11559 CERTIFICATE OF DEATH

11560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>9 Mos. 29 Das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sheppard and Enoch Pratt Hospital</b>		d. STREET ADDRESS <b>2219 Roslyn Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Nannie</b> Middle <b>Buchanan</b> Last <b>Graham</b>		4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas D. Sheppard</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Hamilton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Mrs. Harry K. Cooling-2219 Roslyn Avenue</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>450.0</b> DUE TO Pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Generalized Arteriosclerosis</b> (c) <b>Chronic Brain Syndrome due to Senile Changes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 da</b> <b>?</b> <b>3 yrs +</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome due to Senile Changes</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 8</b> , 19 <b>57</b> , to <b>Nov 7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 7</b> , 19 <b>57</b> , and that death occurred at <b>7:52 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. W. Elgin</b>		M.D. <b>Sheppard and Enoch Pratt Hospital</b>	
PHYSICIAN'S NAME (Type) <b>W. W. Elgin, M. D.</b>		ADDRESS (Street, city or town, state) <b>Towson, Maryland</b>	
DATE SIGNED <b>11/8/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/11/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Jackson &amp; Sons</b>		ADDRESS <b>1111 N. Calver Ave.</b>	
24a. REC'D BY REGISTRAR <b>NOV 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Markel Gray</b>	

**BUREAU V. S.**

NOV 13 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11561

Reg. Dist. No.

11560

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethrope 51</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nursing Home</b>		d. STREET ADDRESS <b>4504 Maple Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George E. Grammer</b> First Middle Last		4. DATE OF DEATH <b>Nov. 23, 1957</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 22, 1880</b> 9. AGE (In years last birthday) <b>76</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Master Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore Co. Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>US</b>
13. FATHER'S NAME <b>George W. Grammer</b>		14. MOTHER'S MAIDEN NAME <b>----- Ebbert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-05-8268</b> 17. INFORMANT <b>Cordelia Grammer, 4504 Maple Ave Balto</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>350x Paralysis organ</b> DUE TO (b) <b>Gravel in entire - left drainage</b> DUE TO (c) <b>4 or 5 days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>27</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>11</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>19.17</b> to <b>Nov 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 23</b> , 19 <b>57</b> , and that death occurred at <b>6:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Fredrick V. Beiter</b>		ADDRESS (Street, city or town, state) <b>10.14 Francis Ave - Balto 27-MD</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>FREDERICK V. BEITER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-26-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore County</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard, 4107 Wilkens Ave</b>		24a. REC'D BY REGISTRAR <b>NOV 27 57</b> 24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of medical examiner		20. Signature of pathologist		21. Signature of anatomist	
22. Signature of bacteriologist		23. Signature of virologist		24. Signature of epidemiologist	
25. Signature of public health nurse		26. Signature of health visitor		27. Signature of sanitarian	
28. Signature of health officer's assistant		29. Signature of health officer's clerk		30. Signature of health officer's stenographer	
31. Signature of health officer's typewriter		32. Signature of health officer's messenger		33. Signature of health officer's janitor	
34. Signature of health officer's porter		35. Signature of health officer's watchman		36. Signature of health officer's night watchman	
37. Signature of health officer's day watchman		38. Signature of health officer's night watchman		39. Signature of health officer's day watchman	
40. Signature of health officer's night watchman		41. Signature of health officer's day watchman		42. Signature of health officer's night watchman	
43. Signature of health officer's day watchman		44. Signature of health officer's night watchman		45. Signature of health officer's day watchman	
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49. Signature of health officer's day watchman		50. Signature of health officer's night watchman		51. Signature of health officer's day watchman	
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61. Signature of health officer's day watchman		62. Signature of health officer's night watchman		63. Signature of health officer's day watchman	
64. Signature of health officer's night watchman		65. Signature of health officer's day watchman		66. Signature of health officer's night watchman	
67. Signature of health officer's day watchman		68. Signature of health officer's night watchman		69. Signature of health officer's day watchman	
70. Signature of health officer's night watchman		71. Signature of health officer's day watchman		72. Signature of health officer's night watchman	
73. Signature of health officer's day watchman		74. Signature of health officer's night watchman		75. Signature of health officer's day watchman	
76. Signature of health officer's night watchman		77. Signature of health officer's day watchman		78. Signature of health officer's night watchman	
79. Signature of health officer's day watchman		80. Signature of health officer's night watchman		81. Signature of health officer's day watchman	
82. Signature of health officer's night watchman		83. Signature of health officer's day watchman		84. Signature of health officer's night watchman	
85. Signature of health officer's day watchman		86. Signature of health officer's night watchman		87. Signature of health officer's day watchman	
88. Signature of health officer's night watchman		89. Signature of health officer's day watchman		90. Signature of health officer's night watchman	
91. Signature of health officer's day watchman		92. Signature of health officer's night watchman		93. Signature of health officer's day watchman	
94. Signature of health officer's night watchman		95. Signature of health officer's day watchman		96. Signature of health officer's night watchman	
97. Signature of health officer's day watchman		98. Signature of health officer's night watchman		99. Signature of health officer's day watchman	
100. Signature of health officer's night watchman		101. Signature of health officer's day watchman		102. Signature of health officer's night watchman	

RECEIVED  
NOV 27 1957  
BUREAU V. S.



## 11561 CERTIFICATE OF DEATH

115628

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Regester Ave.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armecost Nur. Home</b>		d. STREET ADDRESS <b>2952 Keswick Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Virgie</b> Middle <b>C</b> Last <b>Halfpenny</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>30</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 9, 1882</b>
9. AGE (In years lost birth day) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Alberton Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Bradley Stone</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT <b>Son</b>		Address <b>2508 Pengrove Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153X</b> DUE TO <b>Carcinoma of ascending colon</b> Ch. Angiodysplasia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Secondary Anemia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH. <b>2 1/2</b> <b>37.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/5/57</b> , 19____, to <b>11/30/57</b> , that I last saw the deceased alive on <b>11/24/57</b> , 19____, and that death occurred at <b>8:10 PM</b> , from the causes and on the date stated above. <b>W. Stettin</b> M.D. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Mitchell F. Kunkowski</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/3/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	22d. LOCATION (City, town, or county) (State) <b>North Ave.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul A. Heemann</b>		ADDRESS <b>6067 Harford Rd.</b>	
24a. REC'D BY REGISTRAR DATE <b>DEC 6 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mark Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

DEC 6 1957

RECEIVED

## 11481 CERTIFICATE OF DEATH

11563 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>26 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6525 COLGATE AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROLAND</u> Middle <u>LEE</u> Last <u>HALL</u>		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9 FEB. 1892</u>
9. AGE (in years last birthday) <u>65</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CRANE OP.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>AMOS LEE HALL</u>		14. MOTHER'S MAIDEN NAME <u>BETTY CATTERTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-3187</u>	
17. INFORMANT <u>STELLA CHANEY HALL - SAME</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension cardio-vascular disease</u> DUE TO (c) <u>8 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1</u> , 19 <u>54</u> , to <u>11-16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-15</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7001 Mornington Rd Dundalk, Md.</u> DATE SIGNED <u>11-18-57</u>			
ACTUAL SIGNATURE <u>Eugene F Navy</u>		M.D. <u>7001 Mornington Rd Dundalk, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Eugene F Navy</u>		<u>Dundalk, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowdale</u>		22d. LOCATION (City, town, or county) (State) <u>Dundalk, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Bruce Bradley, Dundalk, Md.</u>		ADDRESS <u>Dundalk, Md.</u>	
24a. REC'D BY REGISTRAR <u>Nov 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 12-1-22		6. BIRTH PLACE Tulsa, Oklahoma	
7. MARRIAGE Married		8. DECEASED DATE 11-19-67		9. DECEASED PLACE Baltimore, Maryland	
10. DECEASED TIME 11:00 AM		11. DECEASED HOURS 11		12. DECEASED MINUTES 00	
13. DECEASED MONTH 11		14. DECEASED DAY 19		15. DECEASED YEAR 1967	
16. DECEASED HOURS 11		17. DECEASED MINUTES 00		18. DECEASED MONTH 11	
19. DECEASED DAY 19		20. DECEASED YEAR 1967		21. DECEASED HOURS 11	
22. DECEASED MINUTES 00		23. DECEASED MONTH 11		24. DECEASED DAY 19	
25. DECEASED YEAR 1967		26. DECEASED HOURS 11		27. DECEASED MINUTES 00	
28. DECEASED MONTH 11		29. DECEASED DAY 19		30. DECEASED YEAR 1967	
31. DECEASED HOURS 11		32. DECEASED MINUTES 00		33. DECEASED MONTH 11	
34. DECEASED DAY 19		35. DECEASED YEAR 1967		36. DECEASED HOURS 11	
37. DECEASED MINUTES 00		38. DECEASED MONTH 11		39. DECEASED DAY 19	
40. DECEASED YEAR 1967		41. DECEASED HOURS 11		42. DECEASED MINUTES 00	
43. DECEASED MONTH 11		44. DECEASED DAY 19		45. DECEASED YEAR 1967	
46. DECEASED HOURS 11		47. DECEASED MINUTES 00		48. DECEASED MONTH 11	
49. DECEASED DAY 19		50. DECEASED YEAR 1967		51. DECEASED HOURS 11	
52. DECEASED MINUTES 00		53. DECEASED MONTH 11		54. DECEASED DAY 19	
55. DECEASED YEAR 1967		56. DECEASED HOURS 11		57. DECEASED MINUTES 00	
58. DECEASED MONTH 11		59. DECEASED DAY 19		60. DECEASED YEAR 1967	
61. DECEASED HOURS 11		62. DECEASED MINUTES 00		63. DECEASED MONTH 11	
64. DECEASED DAY 19		65. DECEASED YEAR 1967		66. DECEASED HOURS 11	
67. DECEASED MINUTES 00		68. DECEASED MONTH 11		69. DECEASED DAY 19	
70. DECEASED YEAR 1967		71. DECEASED HOURS 11		72. DECEASED MINUTES 00	
73. DECEASED MONTH 11		74. DECEASED DAY 19		75. DECEASED YEAR 1967	
76. DECEASED HOURS 11		77. DECEASED MINUTES 00		78. DECEASED MONTH 11	
79. DECEASED DAY 19		80. DECEASED YEAR 1967		81. DECEASED HOURS 11	
82. DECEASED MINUTES 00		83. DECEASED MONTH 11		84. DECEASED DAY 19	
85. DECEASED YEAR 1967		86. DECEASED HOURS 11		87. DECEASED MINUTES 00	
88. DECEASED MONTH 11		89. DECEASED DAY 19		90. DECEASED YEAR 1967	
91. DECEASED HOURS 11		92. DECEASED MINUTES 00		93. DECEASED MONTH 11	
94. DECEASED DAY 19		95. DECEASED YEAR 1967		96. DECEASED HOURS 11	
97. DECEASED MINUTES 00		98. DECEASED MONTH 11		99. DECEASED DAY 19	
100. DECEASED YEAR 1967		101. DECEASED HOURS 11		102. DECEASED MINUTES 00	
103. DECEASED MONTH 11		104. DECEASED DAY 19		105. DECEASED YEAR 1967	
106. DECEASED HOURS 11		107. DECEASED MINUTES 00		108. DECEASED MONTH 11	
109. DECEASED DAY 19		110. DECEASED YEAR 1967		111. DECEASED HOURS 11	
112. DECEASED MINUTES 00		113. DECEASED MONTH 11		114. DECEASED DAY 19	
115. DECEASED YEAR 1967		116. DECEASED HOURS 11		117. DECEASED MINUTES 00	
118. DECEASED MONTH 11		119. DECEASED DAY 19		120. DECEASED YEAR 1967	
121. DECEASED HOURS 11		122. DECEASED MINUTES 00		123. DECEASED MONTH 11	
124. DECEASED DAY 19		125. DECEASED YEAR 1967		126. DECEASED HOURS 11	
127. DECEASED MINUTES 00		128. DECEASED MONTH 11		129. DECEASED DAY 19	
130. DECEASED YEAR 1967		131. DECEASED HOURS 11		132. DECEASED MINUTES 00	
133. DECEASED MONTH 11		134. DECEASED DAY 19		135. DECEASED YEAR 1967	
136. DECEASED HOURS 11		137. DECEASED MINUTES 00		138. DECEASED MONTH 11	
139. DECEASED DAY 19		140. DECEASED YEAR 1967		141. DECEASED HOURS 11	
142. DECEASED MINUTES 00		143. DECEASED MONTH 11		144. DECEASED DAY 19	
145. DECEASED YEAR 1967		146. DECEASED HOURS 11		147. DECEASED MINUTES 00	
148. DECEASED MONTH 11		149. DECEASED DAY 19		150. DECEASED YEAR 1967	
151. DECEASED HOURS 11		152. DECEASED MINUTES 00		153. DECEASED MONTH 11	
154. DECEASED DAY 19		155. DECEASED YEAR 1967		156. DECEASED HOURS 11	
157. DECEASED MINUTES 00		158. DECEASED MONTH 11		159. DECEASED DAY 19	
160. DECEASED YEAR 1967		161. DECEASED HOURS 11		162. DECEASED MINUTES 00	
163. DECEASED MONTH 11		164. DECEASED DAY 19		165. DECEASED YEAR 1967	
166. DECEASED HOURS 11		167. DECEASED MINUTES 00		168. DECEASED MONTH 11	
169. DECEASED DAY 19		170. DECEASED YEAR 1967		171. DECEASED HOURS 11	
172. DECEASED MINUTES 00		173. DECEASED MONTH 11		174. DECEASED DAY 19	
175. DECEASED YEAR 1967		176. DECEASED HOURS 11		177. DECEASED MINUTES 00	
178. DECEASED MONTH 11		179. DECEASED DAY 19		180. DECEASED YEAR 1967	
181. DECEASED HOURS 11		182. DECEASED MINUTES 00		183. DECEASED MONTH 11	
184. DECEASED DAY 19		185. DECEASED YEAR 1967		186. DECEASED HOURS 11	
187. DECEASED MINUTES 00		188. DECEASED MONTH 11		189. DECEASED DAY 19	
190. DECEASED YEAR 1967		191. DECEASED HOURS 11		192. DECEASED MINUTES 00	
193. DECEASED MONTH 11		194. DECEASED DAY 19		195. DECEASED YEAR 1967	
196. DECEASED HOURS 11		197. DECEASED MINUTES 00		198. DECEASED MONTH 11	
199. DECEASED DAY 19		200. DECEASED YEAR 1967		201. DECEASED HOURS 11	
202. DECEASED MINUTES 00		203. DECEASED MONTH 11		204. DECEASED DAY 19	
205. DECEASED YEAR 1967		206. DECEASED HOURS 11		207. DECEASED MINUTES 00	
208. DECEASED MONTH 11		209. DECEASED DAY 19		210. DECEASED YEAR 1967	
211. DECEASED HOURS 11		212. DECEASED MINUTES 00		213. DECEASED MONTH 11	
214. DECEASED DAY 19		215. DECEASED YEAR 1967		216. DECEASED HOURS 11	
217. DECEASED MINUTES 00		218. DECEASED MONTH 11		219. DECEASED DAY 19	
220. DECEASED YEAR 1967		221. DECEASED HOURS 11		222. DECEASED MINUTES 00	
223. DECEASED MONTH 11		224. DECEASED DAY 19		225. DECEASED YEAR 1967	
226. DECEASED HOURS 11		227. DECEASED MINUTES 00		228. DECEASED MONTH 11	
229. DECEASED DAY 19		230. DECEASED YEAR 1967		231. DECEASED HOURS 11	
232. DECEASED MINUTES 00		233. DECEASED MONTH 11		234. DECEASED DAY 19	
235. DECEASED YEAR 1967		236. DECEASED HOURS 11		237. DECEASED MINUTES 00	
238. DECEASED MONTH 11		239. DECEASED DAY 19		240. DECEASED YEAR 1967	
241. DECEASED HOURS 11		242. DECEASED MINUTES 00		243. DECEASED MONTH 11	
244. DECEASED DAY 19		245. DECEASED YEAR 1967		246. DECEASED HOURS 11	
247. DECEASED MINUTES 00		248. DECEASED MONTH 11		249. DECEASED DAY 19	
250. DECEASED YEAR 1967		251. DECEASED HOURS 11		252. DECEASED MINUTES 00	
253. DECEASED MONTH 11		254. DECEASED DAY 19		255. DECEASED YEAR 1967	
256. DECEASED HOURS 11		257. DECEASED MINUTES 00		258. DECEASED MONTH 11	
259. DECEASED DAY 19		260. DECEASED YEAR 1967		261. DECEASED HOURS 11	
262. DECEASED MINUTES 00		263. DECEASED MONTH 11		264. DECEASED DAY 19	
265. DECEASED YEAR 1967		266. DECEASED HOURS 11		267. DECEASED MINUTES 00	
268. DECEASED MONTH 11		269. DECEASED DAY 19		270. DECEASED YEAR 1967	
271. DECEASED HOURS 11		272. DECEASED MINUTES 00		273. DECEASED MONTH 11	
274. DECEASED DAY 19		275. DECEASED YEAR 1967		276. DECEASED HOURS 11	
277. DECEASED MINUTES 00		278. DECEASED MONTH 11		279. DECEASED DAY 19	
280. DECEASED YEAR 1967		281. DECEASED HOURS 11		282. DECEASED MINUTES 00	
283. DECEASED MONTH 11		284. DECEASED DAY 19		285. DECEASED YEAR 1967	
286. DECEASED HOURS 11		287. DECEASED MINUTES 00		288. DECEASED MONTH 11	
289. DECEASED DAY 19		290. DECEASED YEAR 1967		291. DECEASED HOURS 11	
292. DECEASED MINUTES 00		293. DECEASED MONTH 11		294. DECEASED DAY 19	
295. DECEASED YEAR 1967		296. DECEASED HOURS 11		297. DECEASED MINUTES 00	
298. DECEASED MONTH 11		299. DECEASED DAY 19		300. DECEASED YEAR 1967	

BUREAU V. S.

NOV 19 1967

RECEIVED

11564

41

VS A15 (4)  
ISM 9/SS







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11562

## CERTIFICATE OF DEATH

11565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b <b>7 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>702 Stoneleigh Rd.</b>				d. STREET ADDRESS <b>702 Stoneleigh Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>B.</b> Last <b>Hardin</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 11, 1877</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		11. BIRTHPLACE (State or foreign country) <b>Nova Scotia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>? Graves</b>				14. MOTHER'S MAIDEN NAME <b>? Parker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Raymond Hardin, 702 Stoneleigh Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio Vascular Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Many years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>19</b>				20g. (County) <b>19</b>			
20h. (State) <b>19</b>				20i. (State) <b>19</b>			
21. I certify that I attended the deceased from <b>Oct 10</b> , 19 <b>53</b> , to <b>Nov 7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 7</b> , 19 <b>57</b> , and that death occurred at <b>7:50 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6805 York Rd Baltimore 12 Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>Laurence C. Post</b> M.D. PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Nr Boston, Mass.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc. 1050 N. York Rd.</b>				24a. REC'D BY REGISTRAR <b>Nov 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

# CERTIFICATE OF DEATH

1957

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF MINISTER

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF PROSECUTOR

18. SIGNATURE OF DEFENSE

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF CLERK

22. SIGNATURE OF JUDGE

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF CORONER

25. SIGNATURE OF PROSECUTOR

26. SIGNATURE OF DEFENSE

27. SIGNATURE OF JURY

28. SIGNATURE OF COURT

29. SIGNATURE OF CLERK

30. SIGNATURE OF JUDGE

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF CORONER

33. SIGNATURE OF PROSECUTOR

34. SIGNATURE OF DEFENSE

35. SIGNATURE OF JURY

BUREAU V. S.

NOV 12 1957

RECEIVED

## CERTIFICATE OF DEATH

11566

Reg. Dist. No.

11563

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM, MD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 TIMONIUM</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>POT SPRING RD</b>		d. STREET ADDRESS <b>POT SPRING RD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELLA H. HARE</b>		4. DATE OF DEATH Month Day Year <b>NOV 29 1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 6, 1870</b>
9. AGE (In years last birthday) <b>87 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>87 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>THOMAS H. JOY</b>		14. MOTHER'S MAIDEN NAME <b>MARY ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>CHARLE EBERSOLE - POT SPRING RD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>422.1</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1957</b> , to <b>Nov. 29 1957</b> , that I last saw the deceased alive on <b>Nov. 24 1957</b> , and that death occurred at <b>3:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.		ADDRESS (Street, city or town, state) <b>TIMONIUM, MD</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>		DATE SIGNED <b>11/29/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/2/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION FREELAND</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO CO, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Austin E. Donovan - 3818 Roland Ave</b>		24a. REC'D BY REGISTRAR <b>DEC 2 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>—</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
MARITAL STATUS		EDUCATION		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

RECEIVED

BUREAU V. S.

DEC 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and is any event within 72 hours after death.

SEND TO: Wm. Reese Mortuary 108 W Washington St Annapolis Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11564 CERTIFICATE OF DEATH

1156744  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ANN ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>15 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b> d. STREET ADDRESS <b>6 NABELL AVENUE, BESTGATE ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>---</b> Last <b>HARRIS</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>28</b> Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 6, 1914</b>
9. AGE (In years last birthday) <b>43</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLUMBER</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. GOVERNMENT</b>		11. BIRTHPLACE (State or foreign country) <b>EDGEWATER, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN W HARRIS</b>	
14. MOTHER'S MAIDEN NAME <b>MARY BROWN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-11</b>	
16. SOCIAL SECURITY NO. <b>214-05-2032</b>		17. INFORMANT Address <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT VASCULAR NEPHRITIS</b> <b>442x</b> DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 WEEKS</b> <b>5 1/2 YEARS</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that <b>VA</b> attended the deceased from <b>NOVEMBER 13, 1957</b> to <b>NOVEMBER 28, 1957</b> and that death occurred at <b>2:15 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>11/29/57</b>	
ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH, Fort Howard, Maryland</b>		PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-2-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEMETERY</b> LOCATION (City, town, or county) (State) <b>HOPE CHAPEL METHODIST CHURCH/ EDGEWATER, MARYLAND</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Law</b> ADDRESS <b>802-04 MADISON AVE BALTO MD</b>	
24a. REC'D BY REGISTRAR <b>DEC 2 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farley</b>	

VS A15 (4)  
15M 9/55

SHIPPED BY Hearse to Wm. Reese Mortuary, 108 W. Washington St., Annapolis, Maryland



RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11565

## CERTIFICATE OF DEATH

11568 43

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Silver Spring Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>R.</b> Last <b>Hastings</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>15,</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1875</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	IF UNDER 24 HRS. Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Accessories</b>		11. BIRTHPLACE (State or foreign country) <b>Preston, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Hastings</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>300-01-3064</b>		17. INFORMANT Address <b>Mrs. Pauline E. Martin Silver Spring Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Malnutrition &amp; Anemia</b> <b>177X</b> DUE TO <b>Carcinomatosis - metastatic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Prostatic Carcinoma.</b> DUE TO <b>2-3 yrs</b> <b>Undet.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1-10 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cystitis &amp; pyuria</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-23-54</b> , 19___, to <b>11-15-57</b> , 19___, that I last saw the deceased alive on <b>11-14-57</b> , 19___, and that death occurred at <b>4p</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7527 Belair Rd Baltimore, Md.</b> DATE SIGNED <b>11-16-57</b>							
ACTUAL SIGNATURE <b>John C. Hyle</b>		M.D. <b>John C. Hyle</b>					
PHYSICIAN'S NAME (Type) <b>JOHN C. Hyle</b>		<b>Baltimore Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 18, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lazarus Funeral Home</b>				ADDRESS <b>7401 Belair Rd</b>		24. REC'D BY REGISTRAR <b>NOV 19 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mrs. A. L. Reifenscheid</b>			

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NOV 19 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11566

## CERTIFICATE OF DEATH

## 11566

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Ruxton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1008 Malvern Ave</b>				d. STREET ADDRESS <b>1 1008 Malvern Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>KIRK</b> Last <b>HECHT</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>2,</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 26, 1900</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Waters Kirk</b>				14. MOTHER'S MAIDEN NAME <b>Kathryn Elizabeth Kimball</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr. Robert E. Hecht - 1008 Malvern Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Partial intestinal obstruction - 154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Recurrence of tumor.</b> DUE TO (c) <b>Carcinoma of rectum.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>  <b>11+ mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan. 1957</b> to <b>Nov. 2, 1957</b> ; that I last saw the deceased alive on <b>Nov. 1, 1957</b> , and that death occurred at <b>9:54 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>108 E. 33rd St. Balto. Md.</b> DATE SIGNED <b>11/4/57</b>							
ACTUAL SIGNATURE <b>Samuel Mc Lanahan</b>				PHYSICIAN'S NAME (Type) <b>Samuel Mc Lanahan M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS - Balto. 17, Md. B.P.B.</b>				24a. REC'D BY REGISTRAR DATE <b>11/5/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

NAME OF DECEASED JOHN WILSON		SEX MALE		AGE 45	
DATE OF DEATH NOV 5 1957		PLACE OF DEATH HOME		COUNTY BALTIMORE	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
PLACE OF BIRTH BALTIMORE, MD		OCCUPATION CLERK		MARITAL STATUS SINGLE	
DATE OF BIRTH NOV 10 1912		PLACE OF BIRTH BALTIMORE, MD		MOTHER'S NAME MARY WILSON	
FATHER'S NAME JOHN WILSON		MOTHER'S NAME MARY WILSON		DATE OF MARRIAGE NOV 10 1935	
DATE OF MARRIAGE NOV 10 1935		PLACE OF MARRIAGE BALTIMORE, MD		MANNER OF DEATH NATURAL	
DATE OF DEATH NOV 5 1957		PLACE OF DEATH HOME		COUNTY BALTIMORE	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
PLACE OF BIRTH BALTIMORE, MD		OCCUPATION CLERK		MARITAL STATUS SINGLE	
DATE OF BIRTH NOV 10 1912		PLACE OF BIRTH BALTIMORE, MD		MOTHER'S NAME MARY WILSON	
FATHER'S NAME JOHN WILSON		MOTHER'S NAME MARY WILSON		DATE OF MARRIAGE NOV 10 1935	
DATE OF MARRIAGE NOV 10 1935		PLACE OF MARRIAGE BALTIMORE, MD		MANNER OF DEATH NATURAL	

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NOV 6 1957

RECEIVED

## CERTIFICATE OF DEATH

1157044

Reg. Dist. No.

11567

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>A.</b> Last <b>HERRING</b>		4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/9/92</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Herring</b>		14. MOTHER'S MAIDEN NAME <b>Mary (Maiden Name Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>213-07-5282</b>	
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction old</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerotic disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Systic disease of lungs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>Unknown</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 9, 19 57</b> , to <b>November 20, 19 57</b> , and that death occurred at <b>1:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>11/20/57</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>CHIENT WEI LAN, M. D.</b> PHYSICIAN'S NAME (Type) <b>FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-22-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick Ammaeast</b>		24a. REC'D BY REGISTRAR DATE <b>10/1/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Darson L. Farley</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Date of registration		12. Place of registration	
13. Name of informant		14. Address of informant		15. Signature of informant	
16. Name of funeral home		17. Address of funeral home		18. Signature of funeral home	
19. Name of cemetery		20. Address of cemetery		21. Signature of cemetery	
22. Name of undertaker		23. Address of undertaker		24. Signature of undertaker	
25. Name of physician		26. Address of physician		27. Signature of physician	
28. Name of nurse		29. Address of nurse		30. Signature of nurse	
31. Name of pharmacist		32. Address of pharmacist		33. Signature of pharmacist	
34. Name of dentist		35. Address of dentist		36. Signature of dentist	
37. Name of optician		38. Address of optician		39. Signature of optician	
40. Name of oculist		41. Address of oculist		42. Signature of oculist	
43. Name of podiatrist		44. Address of podiatrist		45. Signature of podiatrist	
46. Name of chiropractor		47. Address of chiropractor		48. Signature of chiropractor	
49. Name of osteopath		50. Address of osteopath		51. Signature of osteopath	
52. Name of naturopath		53. Address of naturopath		54. Signature of naturopath	
55. Name of other practitioner		56. Address of other practitioner		57. Signature of other practitioner	

BUREAU V. S.

NOV 22 1957

RECEIVED



11568

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex (Balto. 21)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>45 Weber Ave.</b>		d. STREET ADDRESS <b>45 Weber Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First Pauline Middle Last Hetsch</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1879</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Germany</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Langbien</b>		14. MOTHER'S MAIDEN NAME <b>Mary P. Echert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Mrs. Paul C. Fallon</b> Address <b>Same</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarct</b> DUE TO <b>260x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO <b>35</b> (c) <b>Diabetes Mellitus</b> <b>35</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/29</b> , 19 <b>57</b> , to <b>11/29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/29</b> , 19 <b>57</b> , and that death occurred at <b>4:30</b> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin J. Feldman M.D.</b>		ADDRESS (Street, city or town, state) <b>41 Cherry Hill Rd. Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Martin J. Feldman M.D.</b>		DATE SIGNED <b>11/29/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/2/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Highland Presb. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Harford Co. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Bruzdziński</b> ADDRESS <b>1407 Eastern Ave. (21)</b>		24a. REC'D BY REGISTRAR <b>DEC 2 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH	
PLACE OF DEATH		CITY		STATE		COUNTRY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

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11569

## CERTIFICATE OF DEATH

11572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines 16 Fusting Avenue</b>		d. STREET ADDRESS <b>205 N. Tyrone Road #12</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>C. BELLE HEYWOOD</b>		4. DATE OF DEATH Month Day Year <b>11 22 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Feb. 20, 1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Landon C. White</b>		14. MOTHER'S MAIDEN NAME <b>Bettie Lash</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Miss Belle M. Heywood-205 N. Tyrone Road #12</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>15 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-25</b> , 19 <b>54</b> , to <b>11-28</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-28</b> , 19 <b>57</b> , and that death occurred at <b>11:45 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wilmer K. Gallager</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>6209 Frederick Ave Catonsville-28, Md. 11-23-57</b>	
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallager</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/25/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lomine Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tuckner &amp; Sons</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 25 '57</b>	
ADDRESS <b>North &amp; Pa. Aves</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Tuckner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

NOV 26 1957

RECEIVED

11570

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown Md. x2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood Training School</u>				d. STREET ADDRESS <u>113 Neel Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Linda Anne Hobbs</u>				4. DATE OF DEATH Month Day Year <u>Nov. 16, 1957</u> 19			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/27/48</u>		9. AGE (In years last birthday) yrs. <u>9</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elmer H. Hobbs Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy M. Pentz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address <u>Elmer H. Hobbs Jr. 113 Neel Ave. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO 752X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe hypertensive hydrocephaly</u> DUE TO (c) <u>Fetal brain injury</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Rich. Lindenberg (P.M.D.)</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Rich. Lindenberg (P.M.D.)</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran 3000 E. Balto. St. Balto.</u>				24a. REC'D BY REGISTRAR <u>NOV 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESSES	
JAMES EARL RAY		Male		35		May 1, 1932		Memphis, Tennessee		Salesman		Shot by sniper fire		Memphis, Tennessee		10:00 PM		[Signature]		[Signature]	
12. MANNER OF DEATH		13. MARITAL STATUS		14. EDUCATION		15. RELIGION		16. RACE		17. COLOR		18. HEIGHT		19. WEIGHT		20. BUILD		21. COMPLEXION		22. HAIR	
Suicide		Single		High School		Methodist		White		White		5'10"		170 lbs		Slender		Fair		Brown	
23. PREVIOUS ILLNESS		24. PREVIOUS SURGERY		25. PREVIOUS TRAUMA		26. PREVIOUS DRUGS		27. PREVIOUS ALCOHOL		28. PREVIOUS TOBACCO		29. PREVIOUS OTHER		30. PREVIOUS OTHER		31. PREVIOUS OTHER		32. PREVIOUS OTHER		33. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER		37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER		41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER		49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER		53. PREVIOUS OTHER		54. PREVIOUS OTHER		55. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
56. PREVIOUS OTHER		57. PREVIOUS OTHER		58. PREVIOUS OTHER		59. PREVIOUS OTHER		60. PREVIOUS OTHER		61. PREVIOUS OTHER		62. PREVIOUS OTHER		63. PREVIOUS OTHER		64. PREVIOUS OTHER		65. PREVIOUS OTHER		66. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
67. PREVIOUS OTHER		68. PREVIOUS OTHER		69. PREVIOUS OTHER		70. PREVIOUS OTHER		71. PREVIOUS OTHER		72. PREVIOUS OTHER		73. PREVIOUS OTHER		74. PREVIOUS OTHER		75. PREVIOUS OTHER		76. PREVIOUS OTHER		77. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
78. PREVIOUS OTHER		79. PREVIOUS OTHER		80. PREVIOUS OTHER		81. PREVIOUS OTHER		82. PREVIOUS OTHER		83. PREVIOUS OTHER		84. PREVIOUS OTHER		85. PREVIOUS OTHER		86. PREVIOUS OTHER		87. PREVIOUS OTHER		88. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
89. PREVIOUS OTHER		90. PREVIOUS OTHER		91. PREVIOUS OTHER		92. PREVIOUS OTHER		93. PREVIOUS OTHER		94. PREVIOUS OTHER		95. PREVIOUS OTHER		96. PREVIOUS OTHER		97. PREVIOUS OTHER		98. PREVIOUS OTHER		99. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	
100. PREVIOUS OTHER		101. PREVIOUS OTHER		102. PREVIOUS OTHER		103. PREVIOUS OTHER		104. PREVIOUS OTHER		105. PREVIOUS OTHER		106. PREVIOUS OTHER		107. PREVIOUS OTHER		108. PREVIOUS OTHER		109. PREVIOUS OTHER		110. PREVIOUS OTHER	
None		None		None		None		None		None		None		None		None		None		None	

BUREAU V. S.

NOV 19 1967

RECEIVED



11571 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 7 Yr 11 Mo</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville/ Baltimore 16</b> 3401.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Paradise Nurs.Home</b>				d. STREET ADDRESS <b>2732 Riggs Avenue</b> <b>Paradise 1/4 ALEXANDER AVE</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Hoffman</b> Last				4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11, 1875</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Montgomery Reeves</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Walter Gentz, 106 Glenwood Ave Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Degenerative Disease of Eyes with Blindness</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <b>Sept 19 57</b> to <b>2 Nov 57</b> that I last saw the deceased alive on <b>2 Nov 19 57</b> , and that death occurred at <b>1055 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville of Md</b>			
ACTUAL SIGNATURE <b>W.E. Mc Grath M.D.</b>				DATE SIGNED <b>11/5/57</b>			
PHYSICIAN'S NAME (Type) <b>W.E. Mc Grath M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave</b>				24a. REC'D BY REGISTRAR <b>NOV 6 57</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 1, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

NOV 7 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

Item 18 Film 223 12 23-57 ans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11575

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Connecticut</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stamford</b> 45X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Winans Road, Randallstown</b>		d. STREET ADDRESS <b>190 Connecticut Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>EDWARD</b> Last <b>HOFFMAN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min. <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Connecticut; Stamford</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas M. Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Fallie W. Hoffman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Thomas M. Hoffman</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Interstitial Pneumonitis and Possible Sickle Cell Crisis</b> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/29/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 3, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Stamford Connecticut</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ELROY O. WILSON</b>		ADDRESS <b>1000 Brantley Avenue</b>	
24a. REC'D BY REGISTRAR <b>DEC 9 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Jm. Marting</b>	

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RECEIVED  
DEC 9 1957  
BUREAU V. S.

DEC 9 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11573

CERTIFICATE OF DEATH

11576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md.</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum</b> <b>02X2.2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b>		d. STREET ADDRESS <b>558 Cleveland Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>N.</b> Last <b>Holthause</b>		4. DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Calab Phelps</b>		14. MOTHER'S MAIDEN NAME <b>Evelyn Waters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs Edna Janis, daughter, same as 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident with left hemiplegia</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Hypertensive CVD</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <b>11/14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/14</b> , 19 <b>57</b> , and that death occurred at <b>9:55 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert J. Levickas</b>		ADDRESS (Street, city or town, state) <b>5305 East Drive</b>	
PHYSICIAN'S NAME (Type) <b>Herbert J. Levickas</b>		DATE SIGNED <b>11/16/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 25, md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Kirkley</b>		ADDRESS <b>Hopping and Kirkley, Glen Burnie, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 19 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES H. HARRIS		Male		45		White		1910		New York		1955		New York		Heart Disease		Natural		J. H. Harris		J. H. Harris	
13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Teacher		Married		High School		Catholic		None		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. S.

NOV 19 1955

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11577

Reg. Dist. No.

11574

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Kathryn</b> Middle <b>Jane</b> Last <b>Hughes</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>17</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1880</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Henry Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn Lagan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-01-0376</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal pneumonia</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 6, 19 57</b> to <b>NOV. 17, 19 57</b> , that I last saw the deceased alive on <b>NOV. 16, 19 57</b> , and that death occurred at <b>12:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 11/17/57</b>			
ACTUAL SIGNATURE <b>Jonas R. Rapoport</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>Jonas R. Rapoport M.D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>II/21/ 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fleming Fleming</b>		ADDRESS <b>1422 Light St.</b>	
24a. REG'D BY REGISTRAR <b>NOV 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

BUREAU V. F.

NOV 20 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11575

## CERTIFICATE OF DEATH

## 1157838

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Md</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3401-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Nursing Home</b>		d. STREET ADDRESS <b>1368 Washington Blvd</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSE ANN HUMMEL</b> Middle Last		4. DATE OF DEATH Month <b>11-15-57</b> Day Year <b>19</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21, 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Frederick, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>James Ely</b>	
14. MOTHER'S MAIDEN NAME <b>Martha Myers</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Wm. J. Baer, 1019 Elmridge Ave Balto. 29</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 10</b> 19 <b>57</b> to <b>Nov 15</b> 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 15</b> 19 <b>57</b> , and that death occurred at <b>7:45 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Laurence C. Post</b>		DATE SIGNED <b>6905 York Rd Baltimore 12 Md.</b>	
PHYSICIAN'S NAME (Type) <b>LAURENCE C. POST</b>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-18-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>	
24a. REC'D BY REGISTRAR <b>NOV 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 20 1957

RECEIVED

0170

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11576

CERTIFICATE OF DEATH

11579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Convalescent Home</b>		d. STREET ADDRESS <b>Charles &amp; 34th Sts.</b>	
3. NAME OF DECEASED (Type or print) First <b>Lelia</b> Middle <b>Henry</b> Last <b>Hurt</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>26</b> , Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29, 1888</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Easton, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oliver H. Henry</b>		14. MOTHER'S MAIDEN NAME <b>Martha Clark Todd</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Robert M. Hopkins, 1308 Malvern Ave.</b>		Address <b>Ruxton 4, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardio-</b> DUE TO <b>vascular disease</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>5 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Aug. 19, 1957</b> , to <b>Nov. 26, 1957</b> , that I last saw the deceased alive on <b>Nov. 26, 1957</b> , and that death occurred at <b>9 p. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Homer W. Todd</b> M.D.		ADDRESS (Street, city or town, state) <b>2108 St Paul St Baltimore 18 Md</b>	
PHYSICIAN'S NAME (Type) <b>Homer W. Todd</b>		DATE SIGNED <b>11/27/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/29/1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co., Inc.</b>		24a. REC'D BY REGISTRAR <b>11/29/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mabel Gwynn</b>		24c. ADDRESS <b>4905 York Rd., Balto. 12, Md.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
KONIGSON		JAN. 29, 1957	
PLACE OF DEATH		DATE OF BIRTH	
London Convalescent Home		JAN. 29, 1957	
SEX		AGE	
Female		78	
RACE		DATE OF DEATH	
White		JAN. 29, 1957	
MARRIAGE		DATE OF BIRTH	
Married		JAN. 29, 1957	
NAME OF DECEASED		DATE OF DEATH	
KONIGSON		JAN. 29, 1957	
PLACE OF DEATH		DATE OF BIRTH	
London Convalescent Home		JAN. 29, 1957	
SEX		AGE	
Female		78	
RACE		DATE OF DEATH	
White		JAN. 29, 1957	
MARRIAGE		DATE OF BIRTH	
Married		JAN. 29, 1957	

BUREAU V. S.

DEC 3 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11577

CERTIFICATE OF DEATH

115802

Reg. Dist. No. 22

2. DATE OF DEATH 11-30-57

1. NAME OF DECEASED (Type or Print)

MARY HURWITZ

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION

6630 Marott Drive

c. Length of stay in Baltimore

25 Mos. Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)

A. STATE

Md

B. COUNTY

Balto

C. CITY OR TOWN

Baltimore

Co. 10

D. STREET ADDRESS (If rural, give location)

6630 Marott Drive

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

9. AGE (In years last birthday)

77

10. Under 1 Year Months: Days

11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Lith

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Lech

14. MOTHER'S MAIDEN NAME

not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Betty Ehrman - Land

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Cerebral Hemorrhage

1 day

DUE TO

443X ANTECEDENT CAUSES

(B)

Hypertensive C.V. Disease

3 years

DUE TO

(C)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

260X Decubitus Ulcers

25 years

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☐

21a. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22. I certify that (I) (this hospital) attended the deceased from Nov 15 1956 to Nov 30 1957, that (I) (we) last saw the deceased alive on Nov 30 1957, and that death occurred at 11 A m., from the causes and on the date stated above.

23A. SIGNATURE

Manuel Lech

23B. ADDRESS

4818 Reisterstown Rd

23C. DATE SIGNED

Nov 30 1957

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State)

Burial

12-1-57

St Carmel

Balto

Md

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

DEC 1 1957

Manuel Lech

Jack Lewis 2100 Rutland Rd

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information so carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED FOR MAILING

BUREAU V. S.

DEC 4 1957

RECEIVED

## 11578 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. LENGTH OF STAY IN 1b <b>19YR. 10MD</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BALTIMORE COUNTY HOME</b>				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Ivory</b> Last <b>Ivory</b>				4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 8, 1862</b>	
9. AGE (In years lost birthday) <b>94 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Nursery</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>Thomas Patrick Ivory</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Hogen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Balt Co Health Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with gangrene</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1948</b> , to <b>Nov 8, 1957</b> , that I last saw the deceased alive on <b>Nov. 6, 1957</b> , and that death occurred at <b>4:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Elizabeth B. Shernill</b> M.D.				ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED <b>11/8/57</b>			
PHYSICIAN'S NAME (Type) <b>Elizabeth B. Shernill</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>11-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Texas Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Luck</b> ADDRESS <b>130 St. Harford</b>				24a. REC'D BY REGISTRAR DATE <b>11/8/57</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Whitcomb</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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NOV 13 1957

BUREAU V. S.

U.S. DEPARTMENT OF JUSTICE

RECEIVED

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BUREAU V. S.

U.S. DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11582

11579

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balt more 21</b> <b>3V01-4</b>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>643 Dunwich Way</b>				d. STREET ADDRESS <b>1810 East Pratt Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Ethel</b> Middle <b>E.</b> Last <b>Jamison</b>				4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>19 57</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 19, 1883</b>		9. AGE (In years last birthday) yrs. <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>(unknown) Slade</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Wm. H. Jamison, 643 Dunwich Way, Baltimore 21</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral apoplexy</b> DUE TO <b>334X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>5 yrs</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Oct 15</b> , 19 <b>57</b> , to <b>Nov 13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 13</b> , 19 <b>57</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore Md</b> DATE SIGNED <b>11/14/57</b> ACTUAL SIGNATURE <b>Wm Bamgardner</b> M.D. PHYSICIAN'S NAME (Type)															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>11-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>						24a. REC'D BY REGISTRAR DATE <b>NOV 18 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>							

# CERTIFICATE OF DEATH

1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

PLACE OF DEATH

MARRIAGE

AGE

DATE OF BIRTH (If known, give month and day)

SEX

PLACE OF BIRTH (If known, give month and day)

DATE OF DEATH

AGE

DATE OF BIRTH (If known, give month and day)

SEX

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DATE OF BIRTH (If known, give month and day)

DATE OF DEATH

DATE OF BIRTH (If known, give month and day)

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DATE OF DEATH

AGE

DATE OF BIRTH (If known, give month and day)

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NOV 18 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11483 CERTIFICATE OF DEATH

11583

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>BAY View + NT. PT. Rds.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD A JONES</u>		4. DATE OF DEATH Month Day Year <u>11 - 13 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 9 - 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GAS-STATION</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employ</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS C. JONES</u>		14. MOTHER'S MAIDEN NAME <u>DICKEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-09-1994A</u>	
17. INFORMANT <u>DOROTHEA JONES - SAME</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>24hrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-57</u> , 19 <u>57</u> , to <u>11-13-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11-10</u> , 19 <u>57</u> , and that death occurred at <u>6:57 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jack C Collins</u>		ADDRESS (Street, city or town, state) <u>2 Kinship</u> DATE SIGNED <u>11-15-57</u>	
PHYSICIAN'S NAME (Type) <u>JACK C COLLINS</u>		<u>BALTO 22</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK-LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly-Essex Md.</u>		24. REC'D BY REGISTRAR <u>NOV 18 1957</u> 25. REGISTRAR'S SIGNATURE <u>Wm. Kelly</u>	

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NOV 18 1957

BUREAU V. S.

Form with multiple sections and fields, including a large central area with faint text and a small box at the bottom right.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

## 11580 CERTIFICATE OF DEATH

11584 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> <u>06x1.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>Westminster Road</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>E.</u> Last <u>KEETS</u>				4. DATE OF DEATH Month <u>November</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1928</u>	9. AGE (In years last birthday) <u>29</u> yrs.	IF UNDER 1 YEAR Months <u>29</u> Days <u>13</u> Hours <u>13</u> Min. <u>57</u>	IF UNDER 24 HRS. Months <u>29</u> Days <u>13</u> Hours <u>13</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouseman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Upperco, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Keets</u>				14. MOTHER'S MAIDEN NAME <u>Edna Keets</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Korean</u>		16. SOCIAL SECURITY NO. <u>214-32-2784</u>		17. INFORMANT Address <u>Clin. Rec., Vets. Admin. Hospital, Ft. Howard, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GLIOMA OF SPINAL CORD.</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>VA</u> 19 <u>57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>August 23, 1957</u> , to <u>November 13, 1957</u> . I had no other cause of death and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Chien Wei Lan</u>		M.D. <u>VAH FT. HOWARD, MARYLAND</u>		DATE SIGNED <u>11/13/57</u>			
PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN, M.D.</u>		ADDRESS <u>VAH Ft. Howard, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Piny Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Boring, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Tipton</u> ADDRESS <u>Hampstead, Maryland</u>				24a. REC'D BY REGISTRAR <u>NOV 20 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Sawyer L. Parker</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 2

NOV 30 1957

RECEIVED

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be axed within 24 hours after death. The best copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11585

11581

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RANDHILSTOWN</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>		<u>3V014</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8929 CHURCH LANE</u>				STREET ADDRESS (If rural give location) <u>3501 ST PAUL ST</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MINNIE</u> (Middle) <u>V.</u> (Last) <u>KELLY</u>				(Month) <u>NOV.</u> (Day) <u>7</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>AUG 28-1887</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>FRANK BELT</u>				14. MOTHER'S MAIDEN NAME <u>SARAH MCKENZIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>EDWARD KELLY 3501 ST PAUL ST</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>						<u>3 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>MYOCARDIAL FAILURE</u>						<u>3 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CORONARY THROMBOSIS</u>						<u>18 weeks</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 25</u> , 19 <u>57</u> , to <u>Nov. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 7</u> , 19 <u>57</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Donald McKenney</u>				ADDRESS (Street, city, town, state) <u>M.D. 8821 Liberty Rd. Randalltown</u>		DATE SIGNED <u>Nov. 8, 1957</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>11/11/57</u>	NAME OF CEMETERY OR CREMATORY <u>LOUDON PK</u>		LOCATION (City, town, or county) <u>BALTIMORE</u>		(State) <u>MD</u>	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Dr. Thos E. Martin</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence F. Hoffmann</u>		ADDRESS <u>3218 Hudson St</u>			
DATE <u>NOV 12 1957</u>							



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NOV 12 1957

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11/11/72 London BK. Baltimore MD  
 American Film Institute 219, 220, 221



11582

## CERTIFICATE OF DEATH

Reg. Dist. No. 485

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Rosewood State Training School</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u> c. LENGTH OF STAY IN TB <u>4 mo., 4 days</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> <u>12312</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>				d. STREET ADDRESS <u>2 Hanover Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Shirley</u> Middle <u>Oscar</u> Last <u>Kelly</u>				4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/19/56</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Harrison Wesley Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Hazel Mae Branch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Rosewood Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> <u>Bronchitis-Pneumonia</u> DUE TO (b) <u>Acute Bronchitis</u> DUE TO (c) <u>Secondary Anemia</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>9 days</u> <u>4 mos -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>11:20 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Owings Mills, Md</u> DATE SIGNED <u>11/6/57</u>							
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D.				PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>				22b. DATE THEREOF <u>Nov 29/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Abraham Harford</u>	
22d. LOCATION (City, town, or county) (State) <u>Abraham Harford Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tamm</u> ADDRESS <u>Abraham Md</u>				24a. REC'D BY REGISTRAR <u>Nov-7-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mary Elmer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and medical history. The form is partially filled out with handwritten text.

BUREAU V. S.

NOV 12 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

Item 18 Film 225 12-8-57 ams										11583		11587 45		
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No.				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>420 Riverside Drive</b>										d. STREET ADDRESS <b>420 Riverside Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>L.</b> Last <b>KEMP</b>					4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>19 57</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 2 - 1942</b>		9. AGE (In years last birthday) <b>15</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Boy</b>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>BALTO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				
13. FATHER'S NAME <b>WALTER KEMP</b>					14. MOTHER'S MAIDEN NAME <b>Buedel</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <b>PARENTS</b>		Address <b>SAME</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia Complicating old thoracic Polio Deformity</b> 491 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>081 X</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE 					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <b>11/5/57</b>				
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF <b>Nov 8 - 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CAK - LAW N</b>			22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>						
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Connelly - Essex Md.</b>					24a. REC'D BY REGISTRAR <b>NOV 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>							

STATE OF  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8.

NOV 12 1957

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*[Handwritten Signature]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11588

## CERTIFICATE OF DEATH

Reg. Dist. No.

11584

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr6mth16dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Magdalena</b> Middle <b>B.</b> Last <b>Keuchen</b>		4. DATE OF DEATH Month <b>11</b> Day <b>23</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Neurnberg, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>Germany</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic brain syndrome due to cerebral arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>not</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 15</b> , 19 <b>57</b> , to <b>Oct. 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Oct. 23</b> , 19 <b>57</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11-23-57</b>			
ACTUAL SIGNATURE <b>J. Vasconcellos</b> M.D.		DATE SIGNED <b>11-23-57</b>	
PHYSICIAN'S NAME (Type) <b>J. VASCONCELLOS</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11-25-57</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		22d. LOCATION (City, town, or county) (State) <b>Balt Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		24a. REC'D BY REGISTRAR <b>NOV 26 '57</b>	
ADDRESS <b>5305 Hayford</b>		24b. REGISTRAR'S SIGNATURE <b>Reich</b>	

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
HOME		JAN 10 1957	
COUNTY		CITY	
BALTIMORE		BALTIMORE	
STREET		APARTMENT	
1234 E. BALTIMORE		5	
DECEASED		SEX	
JOHN DOE		MALE	
AGE		RACE	
65		WHITE	
MARRIED		OCCUPATION	
YES		RETIRED	
SPOUSE		CAUSE OF DEATH	
JANE DOE		HEART DISEASE	
BORN		MANNER OF DEATH	
JAN 1 1900		NATURAL	
FATHER		EDUCATION	
JOHN DOE		HIGH SCHOOL	
MOTHER		RELIGION	
JANE DOE		CATHOLIC	
SISTER		SIGATURE OF DECEASED	
MARY DOE			
BROTHER		SIGNATURE OF PHYSICIAN	
JOHN DOE			
Nephew		SIGNATURE OF WITNESS	
JOHN DOE			
Uncle		SIGNATURE OF DECEASED	
JOHN DOE			
Aunt		SIGNATURE OF PHYSICIAN	
JANE DOE			
Cousin		SIGNATURE OF WITNESS	
JOHN DOE			
Niece		SIGNATURE OF DECEASED	
MARY DOE			
Son		SIGNATURE OF PHYSICIAN	
JOHN DOE			
Daughter		SIGNATURE OF WITNESS	
JANE DOE			
Grandson		SIGNATURE OF DECEASED	
JOHN DOE			
Granddaughter		SIGNATURE OF PHYSICIAN	
JANE DOE			
Great-grandson		SIGNATURE OF WITNESS	
JOHN DOE			
Great-granddaughter		SIGNATURE OF DECEASED	
MARY DOE			
Great-great-grandson		SIGNATURE OF PHYSICIAN	
JOHN DOE			
Great-great-granddaughter		SIGNATURE OF WITNESS	
JANE DOE			

BUREAU V. S.

NOV 02 1957

RECEIVED

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE PHYSICIAN AND WITNESS. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON.



11585

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Shipley Heights, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>3yr4mth6dys</b>		d. STREET ADDRESS <b>Andover Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Steve</b> Middle <b>Krainer</b> Last <b>Krainer</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1876</b>
9. AGE (In years last birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR Months <b>02</b> Days <b>22</b> Hours <b>02</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Czechoslovakia</b>	
11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Czechoslovakia</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 23</b> , 19 <b>54</b> , to <b>Nov. 29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 29</b> , 19 <b>57</b> , and that death occurred at <b>3:10 a. m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>11-29-57</b>			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-3-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 3 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1583

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

440 CHS 10

NAME OF DECEASED JAMES EARL RAY		DATE OF BIRTH 10-10-1928		PLACE OF BIRTH MOBILE, ALABAMA	
MIDDLE NAME EARL		DATE OF DEATH 4-4-1968		PLACE OF DEATH MEMPHIS, TENNESSEE	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
MARRIED YES		OCCUPATION CONGRESSMAN		RELIGION METHODIST	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		CERTIFICATE OF DEATH YES	
DATE OF BURIAL 4-10-1968		PLACE OF BURIAL MEMPHIS, TENNESSEE		NAME OF FUNERAL HOME JAMES EARL RAY FUNERAL HOME	
NAME OF NEXT OF KIN JAMES EARL RAY, JR.		ADDRESS 1000 17th Avenue S.W.		CITY ALBUQUERQUE, N.M.	
STATE NEW MEXICO		ZIP CODE 87102		DATE OF BIRTH 10-10-1928	
NAME OF NEXT OF KIN JAMES EARL RAY, JR.		ADDRESS 1000 17th Avenue S.W.		CITY ALBUQUERQUE, N.M.	
STATE NEW MEXICO		ZIP CODE 87102		DATE OF BIRTH 10-10-1928	
NAME OF NEXT OF KIN JAMES EARL RAY, JR.		ADDRESS 1000 17th Avenue S.W.		CITY ALBUQUERQUE, N.M.	
STATE NEW MEXICO		ZIP CODE 87102		DATE OF BIRTH 10-10-1928	

BUREAU V. S.

DEC 3 1957

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CERTIFICATE OF DEATH

Reg. Dist. No. 37

11586

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sparks</u>	LENGTH OF STAY (in this place) <u>3 mos.</u>	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cockeysville Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Glencoe Rd.</u>		STREET ADDRESS (If rural give location) <u>Shawan Rd.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HARRIET Cleveland KRAUS</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>11-29 19 57</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH: <u>4-5-1885</u>
9. AGE last birthday: <u>72</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>Asst. manag.</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>swimming pool</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas Kurtz</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Lutz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>219-36-1077</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Jeannette Foster, Sparks, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH.		Interval Between Onset And Death
153x Immediate cause (a) <u>Carcinoma of colon</u>		<u>18 months</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Metastasis of liver &amp; cachexia</u>		<u>1 yr.</u>
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: <u>11-29-57</u>		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>✓</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>✓</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>✓</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>11-27-57</u> , to <u>11-29-57</u> , that I last saw the deceased alive on <u>11-27-57</u> , and that death occurred at <u>Reisterstown Md</u> from the causes and on the date stated above.		
SIGNATURE <u>Samuel L. Saffell M.D.</u> (Degree or title)		DATE SIGNED <u>11-29-57</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>12-1-57</u>	NAME OF CEMETERY OR CREMATORY <u>Jessops Methodist</u>
LOCATION (City, town, or county) (State) <u>Sparks, Md.</u>		
DATE REC'D BY LOCAL REGISTRAR <u>11/30/57</u>	REGISTRAR'S SIGNATURE <u>J. L. Wilson</u>	24. FUNERAL DIRECTOR ADDRESS <u>Books Funeral Service, Towson, Md.</u>

RECEIVED

DEC 4 1957

BUREAU V. S.

## 11587 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>60 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CONRAD</b> Middle <b>JOSEPH</b> Last <b>LAMBERT</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 29, 1892</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas B. Lambert</b>				14. MOTHER'S MAIDEN NAME <b>Mary Sherman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-34-8978</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED CARCINOMATOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHOGENIC CARCINOMA, LEFT LUNG</b> DUE TO (c) <b>UNKNOWN</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>VA</b> Day <b>19</b> Year <b>1957</b> Hour a. m. <b>3:55P</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Baltimore, Maryland</b>				20g. (County) (State)			
21. I certify that I attended the deceased from <b>September 6, 1957</b> , to <b>November 5, 1957</b> , and that death occurred at <b>3:55P M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>11/5/57</b>							
ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b>							
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Tickner &amp; Sons, Inc., North &amp; Penna. Aves.</b>				24a. REC'D BY REGISTRAR <b>11/7/57</b>		24b. REGISTRAR'S SIGNATURE <b>Sawson L. Harber</b>	
Baltimore, Maryland							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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COPY 5 PLACED IN THE RECORD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11588 CERTIFICATE OF DEATH

11592  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>1222 Maple Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clara May Lamison</b>		4. DATE OF DEATH Month Day Year <b>11 29 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 15 1895</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Rogers</b>		14. MOTHER'S MAIDEN NAME <b>Clara Krauch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Hospital records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis Acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Tuberculosis</b> DUE TO (c) <b>—</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>4 1/2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-15</b> , 19 <b>53</b> , to <b>11-29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-29-57</b> , 19 <b>57</b> , and that death occurred at <b>6:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED			
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. <b>Mt. Wilson, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Roper Rindley</b>		ADDRESS <b>Blacksburg, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DEC 2 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Beatty Newell</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11589 CERTIFICATE OF DEATH

Reg. Dist. No.

11593 2

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b> c. LENGTH OF STAY IN 1b <b>06 27.2</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b> d. STREET ADDRESS <b>101 E. GREEN</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>AUGUST</b> Last <b>LEACH</b>		4. DATE OF DEATH Month <b>11</b> Day <b>3</b> Year <b>1957</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-78</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>7</b>	IF UNDER 24 HRS. Days <b>3</b> Hours <b>11</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE CO.</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>MICHAEL LEACH</b>		14. MOTHER'S MAIDEN NAME <b>MARY O'CONNELL</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of the LUNGS</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4 months</b> DUE TO (c)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7-15</b> , 19 <b>57</b> , to <b>11-3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-3</b> , 19 <b>57</b> , and that death occurred at <b>8:00</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>NOV 8 1957</b>						
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.						
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D., Superintendent</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-6-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LONG GREEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HYDE MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>David C. Bankard</b>		ADDRESS <b>Westminster Md</b>		24a. REC'D BY REGISTRAR <b>NOV 8 1957</b>		
24b. REGISTRAR'S SIGNATURE <b>Anthony Newell</b>						

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
BALTIMORE, MARYLAND

CHARLOTTE

WILLIAM

BUREAU V. 1

NOV 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G222 11-20-57 et

CERTIFICATE OF DEATH

11594

Reg. Dist. No.

38

11590

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson, Md.</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sheppard and Enoch Pratt Hospital</b>		d. STREET ADDRESS <b>12X07</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mortimer</b> Middle <b>—</b> Last <b>Lenane</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>8</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29, 1904</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Recreation in Physical Education</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York, N.Y. U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Mortimer Lenane</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-18-3789</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>Mrs Mortimer Lenane</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 720.1 DUE TO <b>Chr. Coronary disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>002x Pulmonary Tuberculosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1, 1957</b> to <b>Nov. 8, 1957</b> , that I last saw the deceased alive on <b>Nov. 8, 1957</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William W. Elgin, M.D.</b>		ADDRESS (Street, city or town, state) <b>Sheppard Pratt Hosp. Towson - A. Md.</b>	
DATE SIGNED <b>11/8/57</b>			
PHYSICIAN'S NAME (Type) <b>William W. Elgin, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 11, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cem. Harford Co., Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Bailey</b>		ADDRESS <b>Charlottesville Md</b>	
24a. REC'D BY REGISTRAR <b>Nov. 9, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles C. Gray</b>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

DECEASED

PLACE OF DEATH

DECEASED AND DEATH CERTIFICATE

BUREAU V. 3

NOV 15 1967

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11595

11491

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Halethorpe</b>	
f. STREET ADDRESS <b>1930 Northeast Avenue</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>LEWIS</b> Last <b>LEWIS</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph A. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Mary Pricilla Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Herbert Lewis</b>	
17. INFORMANT <b>Herbert Lewis</b>		Address <b>1930 Northeast Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitral Insufficiency</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiac Disease</b> DUE TO (c) <b>?</b>			INTERVAL BETWEEN ONSET AND DEATH <b>95 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 481X <b>Influenza Oct. 6 to Oct 20/1957</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>I/31/55</b> , 19____, to <b>II/5/57</b> , 19____, that I last saw the deceased alive on <b>II/5/57</b> , 19____, and that death occurred at <b>3.30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. F. Maloney, M.D.</b> M.D. <b>57 Winters Lane</b> DATE SIGNED <b>II/5/57</b>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <b>C. F. Maloney, M.D.</b>		<b>Catonsville, 28, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 8, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Arbutus; Baltimore County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ELROY O. WILSON</b>		ADDRESS <b>1000 Brantley Avenue</b>	
24a. REC'D BY REGISTRAR <b>NOV 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. E. M. Keffey</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		65		1890		Maryland		Baltimore		Maryland		United States	
RACE		COLORED		WHITE		OTHER		RELIGION		MARRIAGE		MARRIED		SINGLE	
White		White		White		White		Roman Catholic		Married		Married		Single	
EDUCATION		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING	
High School		High School		High School		High School		High School		High School		High School		High School	
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
Teacher		Teacher		Teacher		Teacher		Teacher		Teacher		Teacher		Teacher	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
Natural		Natural		Natural		Natural		Natural		Natural		Natural		Natural	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
Nov 12 1957		Nov 12 1957		Nov 12 1957		Nov 12 1957		Nov 12 1957		Nov 12 1957		Nov 12 1957		Nov 12 1957	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
Home		Home		Home		Home		Home		Home		Home		Home	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
Nov 12 1957		Nov 12 1957		Nov 12 1957		Nov 12 1957		Nov 12 1957		Nov 12 1957		Nov 12 1957		Nov 12 1957	

BUREAU V. S.

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11591 CERTIFICATE OF DEATH

11596

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-BALTO.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring.</u> 1556.2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2306 Rolling Rd. (visiting)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DELBERT LEONARD LINDGREN</u>		4. DATE OF DEATH Nov. 24 1957	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1906
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Photo Engraver (newspaper)</u>	
11. BIRTHPLACE (State or foreign country) <u>Jamestown, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Peter Magnus Lindgren</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Christine Wicklund</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-10-2429</u>	
17. INFORMANT <u>Mrs. Katherine Flynn Lindgren, Silver Spring, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> (c) <u>CARDIAC ISCHEMIA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>10 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV 24</u> , 1957, to <u>NOV 24</u> , 1957, that I last saw the deceased alive on <u>NOV 24</u> , 1957, and that death occurred at <u>5:40 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3424 Abbe Place, Balt. 7, MD.</u> DATE SIGNED <u>11/23/57</u>			
ACTUAL SIGNATURE <u>Joseph W. Cavallaro</u>		PHYSICIAN'S NAME (Type) <u>JOSEPH W. CAVALLARO</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/27/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>NOV 26 57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

(Medical Examiner notified and approved)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 26 1957

RECEIVED

## 11592 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Co. Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in Jones</i>		d. STREET ADDRESS <i>1217 William St.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>FLORENCE M. LINDON</i>		4. DATE OF DEATH Month Day Year <i>11 29 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-20-1886</i>
9. AGE (In years last birthday) <i>71</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Auer</i>		14. MOTHER'S MAIDEN NAME <i>Hennetta Auer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Hypertensive Cardio-vascular Disease</i> DUE TO (c) <i>Diabetes</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>103 (C)</i> <i>1520</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1-4-1957</i> to <i>11-29-1957</i> , that I last saw the deceased alive on <i>11-28-1957</i> , and that death occurred at <i>4:00</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wilmer K. Gallager</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>11-29-57</i>	
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallager</i>		<i>Catonville 28, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/2/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross</i>	22d. LOCATION (City, town, or county) (State) <i>Ritchie Highway</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Fuhry</i>		ADDRESS <i>1318 Light</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Antonia</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. S.**

DEC 3 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11593 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11598  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff</u>		c. LENGTH OF STAY IN 1b <u>7 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Notch Cliff Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Garland</u> Middle <u>R</u> Last <u>Linkous</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>8</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1922</u>
9. AGE (In years last birthday) <u>35</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet metal worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air Plane Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Linkous</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Fain</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>227-18-7058</u>	
17. INFORMANT <u>Ida Linkous</u>		Address <u>9907 Harford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> <u>973.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , <u>Suicide</u> <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>William V. Pratt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-9-57</u>	
22a. BURIAL, CREMATION, REBURY (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 14, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Blacksburg</u>		22d. LOCATION (City, town, or county) (State) <u>Blacksburg Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans &amp; Son</u>		ADDRESS <u>8802 Harford Rd.</u>	
24a. REC'D BY REGISTRAR <u>NOV 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Markel Gray</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 12 1957

RECEIVED

11594

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b> X0			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3811 Seven Mile Lane</b>				d. STREET ADDRESS <b>3811 Seven Mile Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY ELIZABETH LONG</b>				4. DATE OF DEATH Month Day Year <b>Nov. 15, 1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1899</b>		9. AGE (In years last birthday) <b>58</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James Joseph</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Mary Conor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr. Bernard A. Long, Sr. - 3811 Seven Mile Lane</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal Hemorrhage (Gastroenteric)</b> DUE TO <b>581.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of the liver</b> DUE TO (c) <b>10 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized. Obesity</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>Nov</b> , 19 <b>57</b> , to <b>Nov</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov</b> , 19 <b>57</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Pikesville 8, Md</b> DATE SIGNED <b>11/17/57</b>							
ACTUAL SIGNATURE <b>Louis Dalman</b> M.D.		PHYSICIAN'S NAME (Type) <b>Louis DALMAN M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/19/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) <b>Balto., Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS</b> ADDRESS <b>Balto. 17, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>11/18/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Newell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

NOV 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11595 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12820  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>1609 Wilson Pt Road</u>		d. STREET ADDRESS <u>1609 Wilson Pt. Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Julia Malecki Lisiecki</u> First Middle <u>Malecki</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 21 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Lisiecki</u>		14. MOTHER'S MAIDEN NAME <u>Boktek</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. Gardiner</u>		Address <u>1609 Wilson Pt Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>— ? —</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 3, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W Ozagowski</u>		24a. REC'D BY REGISTRAR <u>Edith Kurley</u>	
ADDRESS <u>19309 Eastern Ave</u>		DATE <u>12/5/57</u>	



RECEIVED

DEC 10 1957

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON



11596

## CERTIFICATE OF DEATH

1160033

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs 8 mos</u>		d. STREET ADDRESS <u>621 S. Rose Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Tr. School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>F.</u> Last <u>Mantik</u>		4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/24/53</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Mantik (Adopted father)</u>		14. MOTHER'S MAIDEN NAME <u>Doris Holden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Institution Records</u>		Address <u>Owings Mills Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status epilepticus</u> <u>753.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Epilepsia partialis continua</u> DUE TO (c) <u>multiple congenital anomalies of the brain</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 1</u> , 19 <u>56</u> , to <u>Nov. 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/16</u> , 19 <u>57</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest I. Decko</u>		ADDRESS (Street, city or town, state) <u>Rosewood Lane Owings Mills, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Ernest I. Decko</u>		<u>Rosewood School, Owings Mills, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>Nov 20 1957</u>	<u>ST. STANISLAUS</u>	<u>DUNDALK AVE</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mary Falkowski</u>		24a. REC'D BY REGISTRAR <u>Nov 19 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary Elery</u>
ADDRESS <u>Balto 24 Md</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for: PLACE OF DEATH, SEX, AGE, RACE, OCCUPATION, CAUSE OF DEATH, and SIGNATURE. Includes a large handwritten 'A' in the center and 'Doris' in the lower left.

BUREAU V. M.

NOV 19 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>67 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EVERETT</b> Middle <b>M.</b> Last <b>MARCUM</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>5</b> Year <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 10, 1892</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONDUCTOR (TRAIN)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>	
11. BIRTHPLACE (State or foreign country) <b>MONTICELLO, KENTUCKY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>EPHRAIM MARCUM</b>		14. MOTHER'S MAIDEN NAME <b>ABBIE STEVENS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>705-10-0641</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSPITAL, FT. HOWARD, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH WITH METASTASES</b> DUE TO (b) <b>151x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>AUGUST 30</b> , 19 <b>57</b> , to <b>NOVEMBER 5</b> , 19 <b>57</b> , and that I last saw the deceased <b>alive on</b> <b>11:15A</b> , and that death occurred at <b>11:15A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>11/5/57</b>			
ACTUAL SIGNATURE <b>Irving Freeman</b> M.D.			
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-8-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		24a. REC'D BY REGISTRAR <b>NOV 8 1957</b>	
ADDRESS <b>5305 Harford Road</b>		24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farber</b>	

1

BUREAU V. S.

NOV 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11598 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11602 45

1. PLACE OF DEATH a. COUNTY <u>BALTO CO MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WARREN G. H. MARSHALL</u>		4. DATE OF DEATH Month Day Year <u>NOV 23 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21-1921</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B + O. RR</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Geo. H. Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Emma Lee Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.II</u>		16. SOCIAL SECURITY NO. <u>216-12-8820</u>	
17. INFORMANT <u>Frances Marshall</u>		Address <u>930 Lance Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/23/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-28-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATL. FREDERICK RD.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>Essex</u>	
24a. REC'D BY REGISTRAR <u>NOV 26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
1587 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 26 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11599

Item 2 File # 223 12-3-57 et

## CERTIFICATE OF DEATH

116038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacost Nursing Home</b> <b>812 Register Avenue</b>				d. STREET ADDRESS <b>4307 Underwood Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Martin</b> Last <b>Martin</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 29, 1876</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
13. FATHER'S NAME <b>Patrick Martin</b>				14. MOTHER'S MAIDEN NAME <b>Mary Welsh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daniel LeCron, Route #301, Brandywine, Md</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>many years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug. 22, 1957</b> , to <b>Nov. 24, 1957</b> , that I last saw the deceased alive on <b>Nov. 24, 1957</b> , and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>12 E. Eager Street, Baltimore, Md.</b> DATE SIGNED <b>Nov 25, 1957</b> ACTUAL SIGNATURE <b>John Tilden Howard</b> M.D. PHYSICIAN'S NAME (Type) <b>John Tilden Howard, M. D.</b> <b>12 East Eager Street, Baltimore, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b> ADDRESS				24a. REC'D BY REGISTRAR <b>NOV 26 1957</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Robert Gray</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1189

Emp. by  
Mrs. Paul  
4307 Underswood

BUREAU V. S.

NOV 26 1957

RECEIVED

CHIEF OF BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11604

Reg. Dist. No.

11600

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN 1b <u>10 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AT-HOME</u>				d. STREET ADDRESS <u>906 PEN FREN</u>			
3. NAME OF DECEASED (Type or print) <u>Philip S. Massie</u>				4. DATE OF DEATH <u>11-2-1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u>		8. DATE OF BIRTH <u>Dec 2-1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Capany</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>CHARLES MASSIE</u>				14. MOTHER'S MAIDEN NAME <u>VAUGHN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>MAC MASSIE</u>			
17. INFORMANT <u>MAC MASSIE</u>				Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C. Collins</u>				DATE SIGNED <u>11-4-57</u>			
EXAMINER'S NAME (Type) <u>Jack C. Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Nov 4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BAK-LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>				24a. REC'D BY REGISTRAR <u>NOV 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers: Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11601 CERTIFICATE OF DEATH

11605  
33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>8 months</u> x <u>2 Reisterstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>11 Sunnybank Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>EDNA</u> Last <u>MCANALLY</u>		4. DATE OF DEATH <u>November 7 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph McAnally</u>		14. MOTHER'S MAIDEN NAME <u>Frances Marsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218 07 1239</u>	
17. INFORMANT <u>Mrs. Ladye Butterworth</u>		Address <u>11 Sunnybank Drive Reisterstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, generalized</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Carcinoma - breast</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 25, 1957</u> , to <u>November 7, 1957</u> , that I last saw the deceased alive on <u>November 7, 1957</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clarence E. McWilliam</u> M.D.		ADDRESS (Street, city or town, state) <u>Reisterstown, Maryland</u> DATE SIGNED <u>November 8, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 12/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dover Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Reisterstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline &amp; Sons</u> ADDRESS <u>Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR <u>11-8-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>



**BUREAU V. S.**

NOV 12 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11602 CERTIFICATE OF DEATH

Reg. Dist. No. 11606

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>9 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nurs. Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>			
4. DATE OF DECEASED (Type or print) <b>Rev. Dr. Ernest Roedel McCauley</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>7,</b> Year <b>19 57</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1869</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Clergyman</b>			
11. BIRTHPLACE (State or foreign country) <b>Va.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William McCauley</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Shirey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs Annie C. McCauley, 520 McCauley</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CORONARY ARTERY DISEASE</b> DUE TO (c) <b>ARTERIO SCLEROSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>2 YRS</b> <b>10 YRS?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PROBABLE MESENTERIC THROMBOSIS (RATE)</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>AUG 27, 1956</b> to <b>NOV. 7, 1957</b> , that I last saw the deceased alive on <b>NOV. 7, 1957</b> , and that death occurred at <b>7:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3723 EDMONDSON AVE</b> DATE SIGNED <b>11/8/57</b> ACTUAL SIGNATURE <b>Paul R. Ziegler</b> M.D. <b>PAUL R. ZIEGLER 3723 EDMONDSON AVE #29</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Nov. 9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salem Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>				24a. REC'D BY REGISTRAR <b>Nov 12 '57</b> 24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

NOV 12 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11603

## CERTIFICATE OF DEATH

11607 35  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Freeland</u>	
c. LENGTH OF STAY IN 1b <u>30yrs.</u>		d. STREET ADDRESS <u>Ridge Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>McGraw</u>		4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 11 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm Tazwell Co. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert McGraw</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Gillespie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Mary McGraw-Freeland Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOSTATIC PNEUMONIA</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>3 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493x ARTERIO SCLEROTIC HEART DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> o. <u>  </u> p. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>56</u> to <u>Nov. 11</u> , 1957, that I last saw the deceased alive on <u>Nov 18</u> , 1957, and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Cole Bowers</u>		ADDRESS (Street, city or town, state) <u>NEW FREEDOM PA.</u> DATE SIGNED <u>Nov. 12, 1957</u>	
PHYSICIAN'S NAME (Type) <u>S. Cole Bowers M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 14, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Middletown Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Free and Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Local Mortuary, New Freedom Pa.</u>		24a. REC'D BY REGISTRAR <u>Chester L. Fulton</u>	24b. REGISTRAR'S SIGNATURE <u>Chester L. Fulton</u>
DATE <u>11-15-57</u>			

**BUREAU V. S.**

NOV 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11484

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11608

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burkittsville 10x0.2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7711 Trappe Road</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>C.</b> Last <b>MENTZER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1881</b>		9. AGE (In years last birthday) <b>76 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Mc Dade</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Grams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Charles S. Mentzer 7711 Trappe Road-22</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C Collins</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Jack C Collins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>10-26-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 29, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Burkittsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.H. Fecte &amp; Son, Brunswick, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>11/29/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Mr. Kelly</b>	



STATE OF IOWA  
DEPARTMENT OF HEALTH—BATHING  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
NOV 28 1957  
BUREAU V. S.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11604

CERTIFICATE OF DEATH

11609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Cockeysville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baltimore County Home</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carley</u> Middle <u>MORCEN</u> Last <u>MORCEN</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>27</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>approx 70 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>(Address)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia, 10/20/57</u> DUE TO (b) <u>490X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>(deaf mute)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Nov 27</u> , 19 <u>57</u> , to <u>Nov 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 27</u> , 19 <u>57</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Elizabeth B. Sparill</u> M.D.		ADDRESS (Street, city or town, state) <u>Cockeysville, Md.</u> DATE SIGNED <u>1/27/57</u>	
PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sparill</u>		ADDRESS <u>Cockeysville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Board &amp; Anatomy, State of Maryland</u>		22b. DATE THEREOF <u>1/27/57</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Scott Brooks</u> ADDRESS <u>622 York Rd, Towson, Md.</u>		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE <u>M. J. Chikost</u>			

REC 4 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11605 CERTIFICATE OF DEATH

1161044  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Md.</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>610 Arsan Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>LUTHER</b> Middle <b>F.</b> Last <b>MOWBRAY</b>				4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 15, 1896</b>	
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Elkton, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John W. Mowbray</b>				14. MOTHER'S MAIDEN NAME <b>Jane Crawford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>				16. SOCIAL SECURITY NO. <b>228-07-2178</b>		17. INFORMANT Address <b>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> <b>163x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CARCINOMA OF THE LUNG WITH METASTASES TO BONE &amp; BRAIN</b> DUE TO <b>BRAIN</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b> <b>2 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491x</b> <b>CACHEXIA</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November 14, 1957</b> , to <b>November 27, 1957</b> , and that death occurred at <b>11:00 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b> DATE SIGNED <b>11/28/57</b> ACTUAL SIGNATURE <b>Roland D. Ponce de Leon</b> M.D. PHYSICIAN'S NAME (Type) <b>ROLAND D. PONCE DE LEON, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>12-1-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook Funeral Home</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 2 1957</b>			
ADDRESS <b>St. Paul &amp; Preston Sts. Baltimore, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Harmon L. Fisher</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11606

## CERTIFICATE OF DEATH

Reg. Dist. No.

11611 32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Pikesville x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>South Road, Pikesville, Md.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Irene</u> Last <u>Myers</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Wroten</u>		14. MOTHER'S MAIDEN NAME <u>Mary B. Gregory</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Martin R. Myers, South Road, Pikesville,</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 416x DUE TO <u>chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>50 yrs.?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x <u>Pulmonary Tuberculosis - arrested</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 29</u> , 19 <u>57</u> , to <u>Nov. 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 29</u> , 19 <u>57</u> , and that death occurred at <u>4:30 P.</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>6721 Reisterstown Rd. Balto. 15, Md.</u>	
ACTUAL SIGNATURE <u>Bernard Burgin</u> M.D.		DATE SIGNED <u>11-15-57</u>	
PHYSICIAN'S NAME (Type) <u>Bernard Burgin, M. D.</u>		6721 Reisterstown Rd., Baltimore 15, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 30, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac H. Farrell, Pikesville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 2 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Barth Kunkle</u>			







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11612

## 11607 CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. LENGTH OF STAY IN 1b <b>55</b> <b>Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>624 Radcliff Road</b>				d. STREET ADDRESS <b>624 Radcliff Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY CATHERINE NEESON</b>				4. DATE OF DEATH Month Day Year <b>November 8, 1957 19</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1900</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Patrick Dempsey</b>				14. MOTHER'S MAIDEN NAME <b>Mary O'Donnell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Clifton Ward, 624 Radcliff Rd., Towson, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Rectum</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2-3 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>February, 1956</b> , to <b>Nov. 7<sup>th</sup>, 1957</b> , that I last saw the deceased alive on <b>Nov. 7<sup>th</sup>, 1957</b> , and that death occurred at <b>12:52 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>M. K. Quinn</b>				ADDRESS (Street, city or town, state) <b>1927 York Rd, Timonium, Md.</b>			
DATE SIGNED <b>11/14/57</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 12, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Jones</b>				ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov. 12, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>			

BUREAU V. S.

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11608 CERTIFICATE OF DEATH

Reg. Dist. No.

116133

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Butler</u>		c. LENGTH OF STAY IN 1b <u>20 yrs. x 2 Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Run Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Nelson</u> Last <u>Nelson</u>		4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Febr. 22, 1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Manchester, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Price</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Yost</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Charles Nelson</u>		Address <u>Sparks, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Rt. breast</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u> <u>2 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>none</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <u>none</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I attended the deceased from <u>11-4-36</u> , 19 <u>—</u> , to <u>11-7-57</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>11-1-57</u> , 19 <u>—</u> , and that death occurred at <u>6:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. D. Caples</u>		ADDRESS (Street, city or town, state) <u>6 Hanover Rd.</u> DATE SIGNED <u>11-8-57</u>	
PHYSICIAN'S NAME (Type) <u>D. D. Caples, M. D.</u>		<u>Reisterstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/11/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Shaffers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Seven Valleys, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Mary E. Jones</u>	
DATE <u>NOV 12 1957</u>			

NOV 12 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11614 <sup>90</sup>

Reg. Dist. No.

11609

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>1yr6mths17dys</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u> <span style="float: right;">3V014</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>345 Merrydale Road</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Caroline</u> Middle <u>V.</u> Last <u>Nielsen</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>unknown</u>		9. AGE (In years last birthday) <u>88?</u> yrs.		IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Denmark</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>702-03-2006</u>				17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u>Healed infarct, left ventricle</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis, severe, involving coronary arteries</u> (c) <u>    </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of right hip</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt. slipped out of bed on 10-31-57, sustaining a frac. of the right femur.</u>							
20c. TIME OF INJURY Month, Day, Year <u>2:30</u> <u>10-31</u> <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>hospital</u>			
20f. (City or town) <u>Catonsville 28, Md.</u>		(County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>George M. Kieffer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>11-12-57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>			
22d. LOCATION (City, town, or county) <u>Baltimore 29, Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors, 4101 Edmondson</u>							
24a. REC'D BY REGISTRAR DATE <u>11/13/57</u>							
24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrich</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



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NOV 14 1957

**BUREAU V. S.**



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11610

## CERTIFICATE OF DEATH

116154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>(NMI)</b> Last <b>ODEN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/10/94</b>	9. AGE (In years last birthday) <b>63 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Welding Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Oden</b>				14. MOTHER'S MAIDEN NAME <b>Francis (Maiden Number Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI 215-07-2064</b>		17. INFORMANT Address <b>Clin/Recs.Vets.Admin.Hospital., Ft.Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA CONGESTION</b> <b>442x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOLAR - NEPHROSCLEROSIS</b> DUE TO (c) <b>HYPERTENSIVE CARDIO VASCULAR DISEASE</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 Weeks</b> <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 9, 19 57</b> , to <b>November 19, 19 57</b> , that he or she died on <b>November 19, 19 57</b> , and that death occurred at <b>10:00PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Veterans Administration Hospital 11/20/57</b>							
ACTUAL SIGNATURE <i>Chien Wei Lan</i>		M.D. <b>Veterans Administration Hospital</b>					
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M. D.</b>		<b>Fort Howard, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 25, 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>				ADDRESS <b>8024 Madison Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 25 1957</b>	
				24b. REGISTRAR'S SIGNATURE <i>Newton L. Farley</i>			

MEDICAL CERTIFICATION

2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1957

BUREAU V. 3

NOV 25 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11485

CERTIFICATE OF DEATH

11616

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6822 Dunbar Road</u>				d. STREET ADDRESS <u>6822 Dunbar Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN MARTIN OECHSLER</u>				4. DATE OF DEATH Month Day Year <u>Nov. 3, 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1880</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Yard master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Dunmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Oechsler</u>				14. MOTHER'S MAIDEN NAME <u>Don't know</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Dorothy Morrissey 6838 Dunbar Road.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>422.2</u> IMMEDIATE CAUSE (a) <u>CHRONIC Myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 31, 1957</u> to <u>Nov. 3, 1957</u> , that I last saw the deceased alive on <u>Oct. 31, 1957</u> , and that death occurred at <u>6:57</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. B. Davis</u>				ADDRESS (Street, city or town, state) <u>6800 MCKINLEY RD BALTIMORE MD</u>			
PHYSICIAN'S NAME (Type) <u>M. B. DAVIS MD</u>				DATE SIGNED <u>11/5/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Colgate, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>				24a. REC'D BY REGISTRAR <u>NOV 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Am. Kelly</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

11617 40

11611

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reckordville</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>A.</b> Last <b>Pearce</b>		4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 26, 1893</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>F. X. Hooper Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George R. Pearce</b>		14. MOTHER'S MAIDEN NAME <b>Esther A. Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. # 1 217-07-3416</b>	
17. INFORMANT <b>Mrs. Violet H. Pearce</b>		Address <b>Harford Rd. Reckordville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Infarction</b> <b>420.1</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/25</b> , 19 <b>53</b> , to <b>11/18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/18</b> , 19 <b>57</b> , and that death occurred at <b>5:30 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clifford F. Hudson</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Fork Md. 11/18/57</b>	
PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON, FORK, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 21, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fork Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Fork, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lanshan Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
24a. REC'D BY REGISTRAR <b>Dr. Walter H. Hemmick</b>		DATE <b>NOV 21 1957</b>	



BUREAU V. S.

NOV 21 1957

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>			
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swanwick</u>				c. LENGTH OF STAY IN b. <u>20 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Campbell Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
4. DATE OF DEATH <u>Nov 16</u> 19 <u>57</u>				5. STREET ADDRESS <u>2819 Garnet Rd</u>			
6. NAME OF DECEASED (Type or print) <u>Evelyn Z. Pearson</u>				7. DATE OF BIRTH <u>Feb 14, 1881</u>			
8. SEX <u>F</u>				9. AGE (In years last birthday) <u>76</u> yrs.			
10. COLOR OR RACE <u>W.</u>				11. BIRTHPLACE (State or foreign country) <u>md</u>			
12. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				13. CITIZEN OF WHAT COUNTRY? <u>md</u>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house</u>				15. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
16. FATHER'S NAME <u>Thomas Elade</u>				17. MOTHER'S MAIDEN NAME <u>Emma Shugley</u>			
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				19. SOCIAL SECURITY NO. <u>—</u>			
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerotic Heart Disease</u> DUE TO (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
22a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>57</u>				22b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
22c. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>				22d. (City or town) (County) (State)			
23. I certify that I attended the deceased from <u>Dec. 15, 1956</u> to <u>Nov 16, 1957</u> , that I last saw the deceased alive on <u>Nov 15, 1957</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl L. Chambers</u> M.D.				DATE SIGNED <u>Nov 18, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>				ADDRESS (Street, city or town, state) <u>4108 Liberty Hts. Balto - md</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				24b. DATE THEREOF <u>11/19/57</u>			
24c. NAME OF CEMETERY OR CREMATORY <u>Wood Ridge</u>				24d. LOCATION (City, town, or county) (State) <u>Balto md</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Schumann</u>				25a. ADDRESS <u>6067 Stanford Rd</u>			
25b. REC'D BY REGISTRAR <u>Nov 20 1957</u>				25c. REGISTRAR'S SIGNATURE <u>Wm. J. Martin</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]		9. RELIGION [Faint text]		10. EDUCATION [Faint text]	
11. CAUSE OF DEATH [Faint text]		12. MANNER OF DEATH [Faint text]		13. PLACE OF DEATH [Faint text]		14. DATE OF DEATH [Faint text]		15. TIME OF DEATH [Faint text]	
16. SIGNATURE OF PHYSICIAN [Faint text]		17. SIGNATURE OF REGISTRAR [Faint text]		18. SIGNATURE OF WITNESS [Faint text]		19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF NEXT OF KIN [Faint text]	

BUREAU V. 2

NOV 20 1957

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## , 11613 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Nursing Home</u>		d. STREET ADDRESS <u>1118 Beaumont Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>M.</u> Last <u>Peddicord</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>-- Knight</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Kenneth Peddicord</u>		Address <u>113 Osborne Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho - Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb-</u> , 19 <u>52</u> , to <u>Nov-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 25</u> , 19 <u>57</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. J. Fort</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Wether Dec Fort</u>		<u>1118 St. Paul St. Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 29 '57</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. J. Fort</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. RACE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. DATE OF DEATH</p>		<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>		<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESS</p>		<p>13. SIGNATURE OF PHYSICIAN</p>		<p>14. SIGNATURE OF CORONER</p>		<p>15. SIGNATURE OF JUDGE</p>	
<p>16. SIGNATURE OF CLERK</p>		<p>17. SIGNATURE OF REGISTRAR</p>		<p>18. SIGNATURE OF NOTARY</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF DEPUTY SHERIFF</p>	

BUREAU V. S.

NOV 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11620

Reg. Dist. No.

11614

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>51 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9202 Avondale Road, Baltimore</u>	
f. STREET ADDRESS <u>9202 Avondale Road</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>T.</u> Last <u>PETERSON</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 12, 1923</u>
9. AGE (In years last birthday) <u>34</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worker-assembly line</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General Electric</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Peterson</u>		14. MOTHER'S MAIDEN NAME <u>Tinia Karasinski</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>215-14-9954</u>	
17. INFORMANT <u>Clinical Records, Vet. Adm. Hospital, Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF LEFT PAROTIC GLAND</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Operations-3/20/51-Excision of portion of cervical mass for biopsy.</u> <u>4/6/51 Excision of tumor, left parotid gland. 7/19/56-Excision pre-mastoid</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>tissue, left, for biopsy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year <u>VA</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 9, 1957</u> , to <u>November 29, 1957</u> , that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Joseph M. Miller</u>		M.D. <u>VA HOSPITAL, FORT HOWARD, MARYLAND</u> <u>11/29/57</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH M. MILLER, M.D., Chief, Surgical Service</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Schimunek Funeral Home, 2601 E. Madison, Baltimore</u>		24a. REC'D BY REGISTRAR <u>DEC 3 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Lawson L. Parker</u>			



DEC 3 1957

RECEIVED

BUREAU



## 11615 CERTIFICATE OF DEATH

1162143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>overlea</u>				c. LENGTH OF STAY IN 1b <u>2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>22 Glenmore Avenue</u>				d. STREET ADDRESS <u>22 Glenmore Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanora (nora) E Postles</u>				4. DATE OF DEATH Month Day Year <u>Nov. 8 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 12, 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Milton, Delaware</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Macklin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs. George R. Greaves</u>				Address <u>22 Glenmore Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma, Transverse Colon</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, generalized</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 3, 1957</u> to <u>Nov 8, 1957</u> , that I last saw the deceased alive on <u>Nov 6, 1957</u> , and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles V. Sevcik</u> M.D.				DATE SIGNED <u>11/8/57</u>			
PHYSICIAN'S NAME (Type) <u>Charles V. Sevcik</u>				<u>-6- Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>union cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Georgetown Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sevcik Funeral Home 7401 Belair Rd</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>Nov 14 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. A. L. Reardon</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

**BUREAU V. S.**

NOV 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1162231

Reg. Dist. No.

11616

Item 7 FilmG223 11-29-57 et

1. PLACE OF DEATH a. COUNTY <b>34206 GAITHER RD. BALTO CO MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>	c. LENGTH OF STAY IN 1b <b>3 Yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Rockdale</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3437 Gaither Road</b>		d. STREET ADDRESS <b>3437 GAITHER RD</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>WY</b> Last <b>POWELL</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 9, 1917</b>
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (State or foreign country) <b>Va.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Emmette W. Powell</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth Wright</b>
---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>J.W.Powell</b>	Address <b>225 Fayette St. Cumberland, Md.</b>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUNSHOT WOUND OF CHEST</b> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH
---	--	----------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <b>3:30</b> o. m. <b>PM</b> Month, Day, Year <b>NOV 23 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>	20f. (City or town) <b>Pikesville</b> (County) <b>BALTO.</b> (State) <b>MD</b>

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and find that death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE <b>Russell S Fisher</b> M.D.	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED <b>11/23/57</b>
EXAMINER'S NAME (Type) <b>Russell S FISHER</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-25-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>	22d. LOCATION (City, town, or county) (State) <b>Martinsville, Va.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Strong</b>	ADDRESS <b>3707 W. North Ave</b>	24a. REC'D BY REGISTRAR <b>NOV 26 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Dr. Fred Martin</b>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

BUREAU V. 8

NOV 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11617

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

116231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>3400 GAITHER RD BALTO CO MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKDALE</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		1 d. STREET ADDRESS <b>3400 GAITHER RD.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>L</b> Last <b>POWELL</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 22 - 1925</b>
9. AGE (In years last birthday) <b>32</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b>	
IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Earnest L. Gunter</b>		14. MOTHER'S MAIDEN NAME <b>Lettie Hodges</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Harold Skitman</b>		Address <b>Tower Bldg. Balto.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GUNSHOT WOUND OF Head and CHEST</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>CHEST</b> DUE TO (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>3 32 a.m. NOV 23 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R. S. Fisher</b>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. S. FISHER</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/23/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Remove</b>		22b. DATE THEREOF <b>Nov 24 - 57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Bassett, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>NOV 26 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. J. M. Martin</b>	

IN ARMY AND STATE DEPT. OF HEALTH - BATHING 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
NOV 26 1957  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11624 41

## 11486 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK 22</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6781 WOODLEY RD.</u>		d. STREET ADDRESS <u>6781 WOODLEY RD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SCOTT WINFIELD PRITCHARD</u>		4. DATE OF DEATH Month Day Year <u>11/15/1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 12, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PLUMBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE</u>	
11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>IRVIN PRITCHARD</u>		14. MOTHER'S MAIDEN NAME <u>EMMA BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>236-14-9504</u>	
17. INFORMANT <u>S. W. PRITCHARD, JR.</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A-S-C-V Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 HRS</u> <u>104 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260XD Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>1957</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1957</u> to <u>Nov. 15, 1957</u> , that I last saw the deceased alive on <u>Nov. 15, 1957</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.B. Davis</u>		ADDRESS (Street, city or town, state) <u>6800 MORNINGSTAR AVE - 11/16/57</u>	
PHYSICIAN'S NAME (Type) <u>M.B. Davis MD</u>		DATE SIGNED <u>11/16/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MAGDOLETT</u>	22d. LOCATION (City, town, or county) (State) <u>WESTON, W. VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Boudry, Dundalk, MD</u>		24a. REC'D BY REGISTRAR <u>Nov 19 1957</u>	
ADDRESS <u>Dundalk, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Th. Kelly</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11625

## , 11618 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>37yr11mth2dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b> <b>3401-4</b>			
f. STREET ADDRESS <b>4310 Ridgewood Avenue</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Maggie</b> Middle Last <b>Purucker</b>				4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 23, 1870</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Adam Purucker</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmina Schoegel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>Unknbn</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov. 12</b> , 19 <b>57</b> , to <b>Nov. 12</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 12</b> , 19 <b>57</b> , and that death occurred at <b>9:40 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b> <b>11-12-57</b> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b> <b>Catonsville 28, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/14/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mac Nabt + Son</b> ADDRESS <b>28</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 14 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Q. L. Smith</b>	

1

BUREAU V. S.

1901 71 1001

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11619

CERTIFICATE OF DEATH

Reg. Dist. No.

11626

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>3Y01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		d. STREET ADDRESS <u>2604 Loyola Southway</u>	
3. NAME OF DECEASED (Type or print) <u>RACHAEL</u> First Middle Last <u>PUSHKIN</u>		4. DATE OF DEATH <u>11-13-1957</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Max Pushkin</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinomatosis of oesophagus &amp; liver</u> 1999 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 14</u> , 19 <u>57</u> , to <u>Nov 13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>57</u> , and that death occurred at <u>10-1</u> M, from the causes and on the date stated above. DATE SIGNED			
ACTUAL SIGNATURE <u>Charles R. Keelman</u> M.D.		ADDRESS (Street, city or town, state) <u>3700 Park Heights Avenue</u>	
PHYSICIAN'S NAME (Type) <u>Lester N. Kolman, M.D.</u>		Baltimore, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-14-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Devine</u> ADDRESS <u>2100 Butaw Place</u>		24a. REG'D BY REGISTRAR DATE <u>Nov 18 57</u>	24b. REGISTRAR'S SIGNATURE <u>Devine</u>



CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1892		5. PLACE OF BIRTH Maryland		6. OCCUPATION Farmer	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1915		9. NAME OF SPOUSE Mary H. Harris		10. DATE OF DEATH 1957		11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Diabetes		14. PRESENT ILLNESS Myocardial Infarction		15. DATE OF ONSET 1957		16. DATE OF DEATH 1957		17. PLACE OF DEATH Home		18. SIGNATURE OF PHYSICIAN J. H. Harris	
19. SIGNATURE OF NEXT OF KIN Mary H. Harris		20. SIGNATURE OF DECEASED J. H. Harris		21. SIGNATURE OF WITNESS J. H. Harris		22. SIGNATURE OF WITNESS J. H. Harris		23. SIGNATURE OF WITNESS J. H. Harris		24. SIGNATURE OF WITNESS J. H. Harris	

BUREAU V. S.

NOV 15 1957

RECEIVED

1000 Fulton Ave



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

11620 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 3, Film G-222-11/12/57.c											
Reg. Dist. No. 11627 45											
1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex, 21</u>			c. LENGTH OF STAY IN 1b <u>Essex 21 54</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex 21 54</u>			d. STREET ADDRESS <u>307 Homberg Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>James</u> First <u>FRANCIS</u> Middle <u>FRANCIS</u> Last <u>FRANCIS</u>					4. DATE OF DEATH Month <u>NOV.</u> Day <u>5</u> Year <u>1957</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14, 1911</u>		9. AGE (In years last birthday) <u>45</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Care Taker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apartment house</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>1957</u>			
13. FATHER'S NAME <u>Frank R. Rayner</u>					14. MOTHER'S MAIDEN NAME <u>Frances Ott</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>231-07-2522</u>		17. INFORMANT <u>Frances Rayner</u>		Address <u>Same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Tuberculosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>6 yrs</u> (c) <u>6 yrs</u> DUE TO c. <u>6 yrs</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Baltimore</u>		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>M. B. Davis</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>M. B. Davis</u> M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/8/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Bruzdanski</u> ADDRESS <u>1407 Eastern Avenue</u>					24a. REC'D BY REGISTRAR DATE <u>NOV 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>				

11501 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

NOV 7 1957

RECEIVED

**11621**

**CERTIFICATE OF DEATH**

**11628**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. LENGTH OF STAY IN TB <u>x2 Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2626 Hillcrest Ave.</u>				d. STREET ADDRESS <u>5626 Hillcrest Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Augusta Elizabeth Reardon</u> First Middle Last				4. DATE OF DEATH <u>Nov. 23, 1957</u> Month Day Year			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 22, 1903</u>		9. AGE (In years last birthday) <u>54</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Horstman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Pohl</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>James W. Reardon 2626 Hillcrest Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - uterus</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1, 1953</u> , to <u>Nov. 27, 1957</u> , that I last saw the deceased alive on <u>Nov. 22, 1957</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>George Sawyer</u> M.D. <u>4808 Harford Rd.</u>				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>11/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck Inc. 5305 Harford Rd.</u>				24a. REC'D BY REGISTRAR <u>NOV 25 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Barony</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

NOV 25 1957

RECEIVED

11622

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH o. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Timothy's Lane</b>				d. STREET ADDRESS <b>1 St. Timothy's Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>T.</b> Last <b>RIGGIN</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 25, 1885</b>	
9. AGE (In years lost birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>watchman</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Thomas Riffin</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Schneider</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mr. W Elmer Riffin - 5505 Rusk Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, Acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b> <b>unknown</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 3</b> , 19 <b>57</b> , to <b>Nov. 3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 3</b> , 19 <b>57</b> , and that death occurred at <b>10:30A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1 Mallow Hill Ave.,</b> DATE SIGNED <b>10/4/57</b> ACTUAL SIGNATURE <b>Leo J. Gaver</b> M.D. PHYSICIAN'S NAME (Type) <b>Leo J. Gaver, M.D.</b> <b>Baltimore 29, Maryland.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS -</b>				24a. REC'D BY REGISTRAR DATE <b>11/5/57</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



# CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUB HILL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2Cub HILL</u>	
c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9408 OLD HARFORD RD</u>		d. STREET ADDRESS <u>19408 OLD HARFORD RD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>H</u> Last <u>ROBINSON</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 24-1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOCK CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen Motors Corp</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Rose Stokes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>213-10-4290</u>	
17. INFORMANT <u>MRS ARTHUR ROBINSON</u> Address <u>9408 OLD HARFORD RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Aortic Aneurysm</u> DUE TO <u>022x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <u></u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 9, 1957</u> to <u>November 6, 1957</u> , that I last saw the deceased alive on <u>November 6, 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 York Rd</u> DATE SIGNED <u>11/8/57</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell MD</u>		<u>J. J. Johnson #4 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov 12-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans &amp; Son</u> ADDRESS <u>8802 Harford Rd</u>		24a. REC'D BY REGISTRAR <u>NOV 12 1957</u> 24b. REGISTRAR'S SIGNATURE <u>J. J. Johnson</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

NOV 12 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11631

## , 11624 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Robb Nursing Home - 4105 Essex Rd.</u>		d. STREET ADDRESS <u>X Brooklandville</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE</u> <u>ROGGE</u>		4. DATE OF DEATH Month Day Year <u>Nov.</u> <u>16</u> <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 20, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic - housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u> ✓	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Katharine Dabach - Brooklandville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerosis, generalized</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>53</u> , to <u>Mar. 16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Mar. 16</u> , 19 <u>57</u> , and that death occurred at <u>8:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Palmer F. Williams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>PIKESVILLE 8, MD.</u> <u>11-18-57</u>	
PHYSICIAN'S NAME (Type) <u>PALMER F. C. WILLIAMS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM. J. TICKNER &amp; SONS</u>		ADDRESS <u>Balto. 17, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>11/18/57</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Purkey</u>	

**BUREAU V. S.**

NOV 19 1961

RECEIVED

11625

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. NAME OF DECEASED  
(Type or Print)

IDA BLANCHE RUBY

2. DATE

DEATH

NOV. 21, 1957

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Baeto Co

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

Md.

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

1864 Loch Shiel Road

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

xo Baltimore

D. STREET ADDRESS (If rural, give location)

1864 Loch Shiel Road

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

F

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)  
Widowed

8. DATE OF BIRTH

3/25/1888

9. AGE (In years last birthday)

69

10. Under 1 Year Months: Days  
11. Under 24 Hours Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Joseph Countess

14. MOTHER'S MAIDEN NAME

Ella McDonald

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Doris Urban 1864 Loch Shiel Rd.

18.

420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II  
210. TIME (Month) (Day) (Year) (Hour) OF INJURY

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY? YES ☐ NO ☐

21E. INJURY OCCURRED WHILE AT ☐ WORK NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/21/57 to 11/21/57 that (I) (we) last saw the deceased alive on 11/21/57 and that death occurred at 4:45 P. m., from the causes and on the date stated above.

23A. SIGNATURE

Doris Urban

23B. ADDRESS

8358 Loch Raven Blvd

23C. DATE SIGNED

11/22/57

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

11/25/57

24C. NAME OF CEMETERY OR CREMATORY

Glen Haven

24D. LOCATION (City, town, or county)

Glen Burnie, Md.

DATE RECEIVED BY LOCAL REGISTRAR

Nov 23 1957

REGISTRAR'S SIGNATURE

R. W. Matlock

25. FUNERAL DIRECTOR

ADDRESS

JOHN F. DENNY, INC. 715 Light St.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information so carefully supplied. Physicians: please write the causes of death clearly and leg. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED

NOV 28 1957

BUREAU K. S.

OFFICE OF THE ATTORNEY GENERAL



# 1 11626 90 1 VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 11626 90 1 VS A15 (4) 15M 9/55 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 11 Film 6223 12-5-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

11633

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 24</b> <b>3v01-4</b> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RIDGEWAY MANOR</b> <b>5743 Edmondson Avenue</b>				d. STREET ADDRESS <b>3106 East Baltimore Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Beatrice</b> Middle <b>Me</b> Last <b>Rupprecht</b>				4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 2, 1884</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.		IF UNDER 24 HRS. Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Michael Fahey</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Kelly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Gilbert Rupprecht, 27 N. Culver Street, Baltimore</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 28, 19 57</b> to <b>Nov 28, 19 57</b> , that I last saw the deceased alive on <b>Nov 27, 19 57</b> , and that death occurred at <b>3:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6014 Edmondson Ave Balt</b> DATE SIGNED <b>8/26/11/2/67</b>							
ACTUAL SIGNATURE <b>J. Nelson McKay</b> M.D.				PHYSICIAN'S NAME (Type) <b>J. Nelson McKay, M.D.</b> <b>6014 Edmondson Avenue</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-2-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b> ADDRESS				24a. REC'D BY REGISTRAR <b>DATE 57</b>		24b. REGISTRAR'S SIGNATURE <b>Att. Sec'y</b>	



11627

# CERTIFICATE OF DEATH

11634

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore Co.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1159 Granville Rd</b>		d. STREET ADDRESS <b>1159 Granville Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>RUSHWORTH</b> Last <b>RUSHWORTH</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 19, 1872</b>
9. AGE (In years last birthday) yrs. <b>85</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>England</b>	
13. FATHER'S NAME <b>John W. Walker</b>		14. MOTHER'S MAIDEN NAME <b>Mary Walker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Rushworth, 1159 Granville Rd. Catonsville, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterial Sclerosis. Senile Dementia</b> DUE TO (c) <b>Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1955</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 8, 1957</b> to <b>Nov 29, 1957</b> , that I last saw the deceased alive on <b>11/27, 1957</b> , and that death occurred at <b>1030 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2145 W. Baltimore St Baltimore Md</b> DATE SIGNED <b>11/30/57</b>			
ACTUAL SIGNATURE <b>Charles A Cahn</b>		M.D. <b>2145 W. Baltimore St Baltimore Md</b>	
PHYSICIAN'S NAME (Type) <b>Charles A Cahn</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Dec. 2, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Ave. Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas J. Kenny, Inc.</b>		ADDRESS <b>1600 Hollins St.</b>	
24a. REC'D. BY REGISTRAR DATE <b>DEC 4 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

VS A15 (4)  
15M 9/55

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

116358

Reg. Dist. No.

11628

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7008 Heathfield Avenue</u>		e. STREET ADDRESS <u>7008 Heathfield Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs. Meta L. Saft</u>		4. DATE OF DEATH <u>November 2nd, 1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
13. FATHER'S NAME <u>Albin Stopp</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Wagenfuhr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>218-32-7320</u>	
17. INFORMANT <u>Mrs.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>OCCCLUSION OF CORONARY ARTERY HEART</u> <u>420.1</u> DUE TO (b) <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>SENILITY</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 yrs</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Oct 31</u> , 19 <u>57</u> , to <u>Nov 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6210 York Road #12</u> DATE SIGNED <u>11/4/57</u>			
ACTUAL SIGNATURE <u>A. S. Chalfant</u>		M.D. <u>  </u>	
PHYSICIAN'S NAME (Type) <u>Dr. A. S. CHALFANT</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>	
24a. REC'D BY REGISTRAR <u>NOV 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Greys</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

NOV 6 1957

RECEIVED



11629

## CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>				c. LENGTH OF STAY IN 1b <b>43 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8607 Liberty Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Franklin</b> Last <b>Sauter</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>15th.</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21, 1891</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plastering Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Charles Christian Sauter</b>				14. MOTHER'S MAIDEN NAME <b>Eleanor Christina Stirn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-32-1064</b>		17. INFORMANT Address <b>Randallstown Md.</b> <b>Mrs. Maud B. Suter 8607 Liberty Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>One month</b> <b>5 Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/14</b> , 19 <b>57</b> , to <b>11/15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/13</b> , 19 <b>57</b> , and that death occurred at <b>1:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b> M.D.				ADDRESS (Street, city or town, state) <b>8254 LIBERTY RD. BALTO. 7, MD</b>			
PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT</b>				DATE <b>NOV 19 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/18/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorr aine Park</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Spons</b>				ADDRESS <b>Catonsville, Md.</b>		24a. REC'D BY REGISTRAR <b>Dr. M. C. Martin</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page 1 of 1

<p>1. Name of Deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of Birth: <i>1910-01-01</i></p>		<p>4. Date of Death: <i>1957-11-19</i></p>	
<p>5. Place of Birth: <i>Baltimore, Maryland</i></p>		<p>6. Place of Death: <i>Baltimore, Maryland</i></p>	
<p>7. Cause of Death: <i>Heart Disease</i></p>		<p>8. Manner of Death: <i>Natural</i></p>	
<p>9. Signature of Physician: <i>[Signature]</i></p>		<p>10. Signature of Registrar: <i>[Signature]</i></p>	
<p>11. Date of Signature: <i>1957-11-20</i></p>		<p>12. Date of Signature: <i>1957-11-20</i></p>	

BUREAU V. 2

NOV 19 1957

RECEIVED

11630

## CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>				c. LENGTH OF STAY IN 1b <b>356 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>1626 Normal Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Benedict Francis Saraliski</b>				4. DATE OF DEATH Month Day Year <b>Nov 11 1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>7-14-01</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Metal Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Sheet metal</b>		11. BIRTHPLACE (State or foreign country) <b>Midland Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Vincent Saraliski</b>				14. MOTHER'S MAIDEN NAME <b>Anna Dorelich</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>				16. SOCIAL SECURITY NO. <b>24-01-9870</b>		17. INFORMANT Address <b>Hospital records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Nov. 20</b> , 19 <b>56</b> , to <b>Nov. 11</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 11</b> , 19 <b>57</b> , and that death occurred at <b>4:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D. PHYSICIAN'S NAME (Type) <b>WILLIAM NEWCOMER, M. D. Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Cremation</b>		<b>Nov. 14, 1957</b>		<b>GLEN HAVEN CEM.</b>		<b>BALTO. COUNTY MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Edmund Schmitt, 3512 Frederick Ave.</b>				24a. REC'D BY REGISTRAR <b>DATE 11/14/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Towell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF DECEASED: [illegible]  
SIGNATURE OF WITNESS: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF CORONER: [illegible]  
SIGNATURE OF JUDGE: [illegible]  
SIGNATURE OF CLERK: [illegible]

BUREAU V. S.

NOV 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11638

## 11631 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balt.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 12</b>		c. LENGTH OF STAY IN TB <b>9 yrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>xo Baltimore 12</b>		d. STREET ADDRESS <b>6467 Blenheim Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6467 Blenheim Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES - SCHEIDT</b>		4. DATE OF DEATH Month Day Year <b>Nov. 23 19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13. 1877</b>
9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Box maker, retired 5 years</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Scheidt</b>		14. MOTHER'S MAIDEN NAME <b>Louise Pensel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Louise Knoche. 6467 Blenheim Rd. - 12</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Acute Cordae dilatation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ch. Myocarditis</b> DUE TO (c) <b>Styretension - Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>4 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> to <b>Nov 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 23</b> , 19 <b>57</b> , and that death occurred at <b>1 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>3805 Belair Rd Nov 25/77</b> ACTUAL SIGNATURE <b>J. J. Hander</b> M.D. <b>Balt. Md</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 27. 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC. Baltimore Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 27 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>			

# CERTIFICATE OF DEATH

11001

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

11002

PLACE OF BIRTH BALTIMORE, MD		SEX MALE	
DATE OF BIRTH JAN 1 1901		AGE 54	
PLACE OF DEATH BALTIMORE, MD		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JAN 1 1957		TIME OF DEATH 10:00 AM	
PLACE OF INTERMENT BALTIMORE, MD		NAME OF INTERMENT BALTIMORE, MD	
NAME OF DECEASED JOHN J. JONES		NAME OF NEXT OF KIN MARY J. JONES	
ADDRESS OF DECEASED 1234 MAIN ST, BALTIMORE, MD		ADDRESS OF NEXT OF KIN 5678 MAIN ST, BALTIMORE, MD	
OCCUPATION CLERK		EDUCATION HIGH SCHOOL	
MARITAL STATUS MARRIED		DATE OF MARRIAGE JAN 1 1920	
PREVIOUS ILLNESS YES		DATE OF PREVIOUS ILLNESS DEC 15 1956	
NAME OF PHYSICIAN DR. J. J. JONES		NAME OF HOSPITAL BALTIMORE HOSPITAL	
NAME OF FUNERAL HOME BALTIMORE FUNERAL HOME		NAME OF BURIAL PLACE BALTIMORE CEMETERY	
NAME OF MINISTER REV. J. J. JONES		NAME OF CHURCH BALTIMORE CHURCH	
NAME OF CEMETERY BALTIMORE CEMETERY		NAME OF INTERMENT BALTIMORE, MD	
NAME OF DECEASED JOHN J. JONES		NAME OF NEXT OF KIN MARY J. JONES	
ADDRESS OF DECEASED 1234 MAIN ST, BALTIMORE, MD		ADDRESS OF NEXT OF KIN 5678 MAIN ST, BALTIMORE, MD	
OCCUPATION CLERK		EDUCATION HIGH SCHOOL	
MARITAL STATUS MARRIED		DATE OF MARRIAGE JAN 1 1920	
PREVIOUS ILLNESS YES		DATE OF PREVIOUS ILLNESS DEC 15 1956	
NAME OF PHYSICIAN DR. J. J. JONES		NAME OF HOSPITAL BALTIMORE HOSPITAL	
NAME OF FUNERAL HOME BALTIMORE FUNERAL HOME		NAME OF BURIAL PLACE BALTIMORE CEMETERY	
NAME OF MINISTER REV. J. J. JONES		NAME OF CHURCH BALTIMORE CHURCH	
NAME OF CEMETERY BALTIMORE CEMETERY		NAME OF INTERMENT BALTIMORE, MD	

BUREAU V. S.

NOV 27 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11632

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u>		c. LENGTH OF STAY IN 1b <u>54</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>352 Montrose Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Schivane</u> Last <u>Schivane</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-28-1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>13</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ferdinand Fidaro</u>		14. MOTHER'S MAIDEN NAME <u>Raphael</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Heguro Jan. 1900</u>	
17. INFORMANT <u>Mr. Carmel Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c), stating the underlying cause lost. (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jack C Collins</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>11-11-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u>	22d. LOCATION (City, town, or county) (State) <u>Mr. Carmel Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u>		ADDRESS <u>Essey 21 Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Edith Huxley</u>	

BUREAU V. S.

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11492 **CERTIFICATE OF DEATH**

11640

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HALETHORPE</u>		<u>5 yrs.</u>		TOWN <u>HALETHORPE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1811 WINANS AVE.</u>				STREET ADDRESS (If rural give location) <u>1811 WINANS AVE.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>ELIZABETH SCHMELYAN</u>				<u>NOV. 30, 1957</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>FEMALE</u>	<u>WHITE</u>	<u>Widowed</u>	<u>APRIL 19, 1873</u>	<u>84</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>HOUSEWIFE</u>		<u>DOMESTIC</u>		<u>NEW YORK</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>GUTHARDT Knopf</u>				<u>CAROLINE SADOFSKY</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>NO</u>		<u>NONE</u>		<u>MARIE MEETH 1811 WINANS AVE.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>442x Cerebral Thrombosis</u>						<u>1 month</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>							
<u>Arterio-sclerotic Cardio-renal Disease.</u>						<u>Several years</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>				<b>21a. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from <u>November 1, 1957</u> to <u>November 30, 1957</u>, that I last saw the deceased alive on <u>Nov 26, 1957</u>, and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>			
<u>Wm Michel</u>				<u>1015 Poplar Grove St Baltimore Md</u>			
<b>DATE THEREOF</b>				<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>12-3-57</u>				<u>WESTERN</u>		<u>BALTIMORE Md</u>	
<b>24. REC'D BY REGISTRAR</b>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>DEC 3 1957</u>				<u>George L. Schwab 2101 Franklin St</u>			

BUREAU V. S.

DEC 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11641

11487

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11, Film 6223 12-3-57 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk 22</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1931 Dundalk Avenue</u>				d. STREET ADDRESS <u>1931 Dundalk Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Robert Schuck</u>				4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 17, 1903</u>			
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Texaco Service Sta.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Robert Schuck</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-14-2304</u>		17. INFORMANT <u>William F. Schuck, 4424 Findlay Road, Baltimore 6</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341</u> <u>Gestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Jack C. Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>JACK C. COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>11-23-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Taylor Avenue, Baltimore, Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 26 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>Am. Kelly</u>					



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

NOV 26 1957

RECEIVED



11633

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>309 Linden Ave.</b>				d. STREET ADDRESS <b>309 Linden Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>J.</b> Last <b>SCHULTZ</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>2,</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1896</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck Bodies</b>		11. BIRTHPLACE (State or foreign country) <b>Wash., D. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frederick George Schultz</b>				14. MOTHER'S MAIDEN NAME <b>Sophie Kettler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Edna H. Schultz - 309 Linden Ave., Towson</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Left Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Aug 10, 1957</b> to <b>Nov 2, 1957</b> that I last saw the deceased alive on <b>Oct 30, 1957</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Samuel B. Wolfe</b>				ADDRESS (Street, city or town, state) <b>246 E. Burke Ave</b>		DATE SIGNED <b>11-7-57</b>	
PHYSICIAN'S NAME (Type) <b>SAMUEL B. WOLFE</b>				<b>Towson, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Maus.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS - Balto. 17, Md.</b>				24a. REC'D BY REGISTRAR <b>OPR</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11634

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3115 Orchard Road</i>				d. STREET ADDRESS <i>3115 Orchard Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Mr. Herbert T. Shanklin Sr</i>				4. DATE OF DEATH <i>November 15th 19 57</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 31, 1901</i>	
9. AGE (In years last birthday) <i>56</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Guard, Glenn L. Martin Co.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>		11. BIRTHPLACE (State or foreign country) <i>USA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Thomas E. Shanklin</i>				14. MOTHER'S MAIDEN NAME <i>Alice R. Hall</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Marie Rose Shanklin</i> Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Coronary Artery Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>30 minutes</i> <i>2 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>October 19 1957</i> , to <i>11/15 1957</i> , that I last saw the deceased alive on <i>October 19 1957</i> , and that death occurred at <i>6:20 p.m.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>John H. Hirschfeld M.D.</i>				ADDRESS (Street, city or town, state) <i>6919 Harford Road #14</i>		DATE SIGNED <i>11/16/57</i>	
PHYSICIAN'S NAME (Type) <i>John H. Hirschfeld</i>				Baltimore, Maryland			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/19/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Ln</i>		22d. LOCATION (City, town, or county) (State) <i>Bald Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>				24a. REC'D BY REGISTRAR <i>Dr. A. M. Bacon</i>		24b. REGISTRAR'S SIGNATURE	
				DATE <i>NOV 21 1957</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

NOV 21 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN b. <b>50 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>90 Shady Nook Nursing Home</b>				d. STREET ADDRESS <b>508 Old Orchard Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>R. Shermer</b> Last				4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 25, 1884</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS. Days		12. IF UNDER 1 YEAR Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>I. N. W.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>-----Robbins</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-----</b>			
17. INFORMANT <b>Mrs. John C. Dumler, 508 Old Orchard Rd</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X Cardio-Respiratory failure</b> DUE TO (b) <b>Pneumonia, left lower lobe</b> DUE TO (c) <b>Empyema Thymic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1957</b> , to <b>28 Nov. 1957</b> , that I last saw the deceased alive on <b>28 Nov. 1957</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>4605 Edmondson Ave Baltimore 29, Md.</b>							
DATE SIGNED <b>-----</b>							
ACTUAL SIGNATURE <b>William J. Bryson</b> M.D. <b>4605 Edmondson Ave</b>							
PHYSICIAN'S NAME (Type) <b>William J. Bryson</b> <b>Baltimore 29, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 30/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson Ave</b>							
24a. REC'D BY REGISTRAR <b>57</b> 24b. REGISTRAR'S SIGNATURE <b>-----</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 2 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11636

## CERTIFICATE OF DEATH

11645

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN IB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>208 Winters Lane</b>		d. STREET ADDRESS <b>208 Winters Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>SIMPSON</b> Last <b>SIMPSON</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 18, 1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min. <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Simpson</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>M's Josephine Burton</b>	
17. INFORMANT <b>M's Josephine Burton</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>156.1</b> DUE TO (c) <b>156.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8 Nov 1927</b> to <b>15 Nov 1957</b> that I last saw the deceased alive on <b>11 Nov 1957</b> , and that death occurred at <b>6:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>305 A Winters Ave. Balto</b> DATE SIGNED <b>16 Nov 57</b>			
ACTUAL SIGNATURE <b>C. R. Davidson</b>		M.D. <b>305 A Winters Ave. Balto</b>	
PHYSICIAN'S NAME (Type) <b>Charles R. Davidson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-18-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Catonsville, Balto. Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Frances T. Hensley</b>		ADDRESS <b>578 W. Biddle St.</b>	
24a. REC'D BY REGISTRAR <b>Nov 19 57</b>		24b. REGISTRAR'S SIGNATURE <b>Outreach</b>	

**BUREAU V. S.**

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11646

CERTIFICATE OF DEATH

Reg. Dist. No.

11493

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>				c. LENGTH OF STAY IN 1b <b>60 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4503 Wilkens Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Slekis</b> Last <b>Slekis</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 8, 1877</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>I.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	
11. BIRTHPLACE (State or foreign country) <b>Lithuania</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Adam Kadis</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(11 yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO. <b>Mrs Anna Matukaitis, 4503 Wilkens Ave</b>			
17. INFORMANT <b>Mrs Anna Matukaitis, 4503 Wilkens Ave</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio Vasc. Disease</b> DUE TO (c) <b>years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Inanition because of symptoms contributed by cholelithiasis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct. 19 57</b> to <b>Nov 7, 19 57</b> , that I last saw the deceased alive on <b>Nov 5, 19 57</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3322 Frederick Ave. Balto-29, Md.</b> DATE SIGNED <b>11/8/57</b>							
ACTUAL SIGNATURE <b>Abram Goldman, M.D.</b>				PHYSICIAN'S NAME (Type) <b>ABRAM GOLDMAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 11, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave.</b>				24a. REC'D BY REGISTRAR <b>NOV 12 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Dr. G. M. Jeffrey</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. PLACE OF DEATH: [illegible]  
9. DATE OF DEATH: [illegible]  
10. SIGNATURE OF PHYSICIAN: [illegible]  
11. SIGNATURE OF REGISTRAR: [illegible]  
12. SIGNATURE OF WITNESS: [illegible]

RECEIVED  
NOV 12 1957  
BUREAU V. S.

RECEIVED  
NOV 12 1957  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)  
SM 9/55

Item 18 Film 225 12-23-57 <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> 11637 11647 38									
1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knollwood</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knollwood</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7906 Knollwood Rd.</b>					d. STREET ADDRESS <b>7906 Knollwood Rd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MRS. CATHERINE SPALDING SMITH</b>					4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>1957</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 28, 1902</b>		9. AGE (In years last birthday) <b>55</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Ill.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Mark Donovan</b>				14. MOTHER'S MAIDEN NAME <b>Mary Haugh</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr. W. Conwell Smith, Jr. - Brooklandville, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>581.0</b> IMMEDIATE CAUSE (a) <b>Fatty infiltration of liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/16/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM J. TICKNER &amp; SONS</b>				23b. ADDRESS <b>Balto. 17, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 15 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Habel C. Gray</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

NOV 15 1957

RECEIVED

*Remell H. H. H.*



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11638 CERTIFICATE OF DEATH

11648

Reg. Dist. No. 39

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks Md</u>		c. LENGTH OF STAY IN 1b <u>X2 Sparks, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belfast Rd, Sparks, Md.</u>		d. STREET ADDRESS <u>Belfast Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>N.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 21, 1903</u>
9. AGE (In years last birthday) <u>54 yrs.</u>		IF UNDER 1 YEAR Months <u>54</u> Days <u>26</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles M. Therit</u>		14. MOTHER'S MAIDEN NAME <u>Clara Miller.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Charles R. Smith. 3000 Keswick Rd, Md</u>	
17. INFORMANT <u>Charles R. Smith. 3000 Keswick Rd, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Consecutive HEART FAILURE</u> 260x DUE TO (b) <u>CORONARY ARTERIO-SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Diabetes MELLITUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>6 MO</u> <u>2 yrs</u> <u>10-12 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 25, 1957</u> , to <u>Nov. 26, 1957</u> , that I last saw the deceased alive on <u>Nov. 25, 1957</u> , and that death occurred at <u>5a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porter field</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u>	
DATE SIGNED <u>11-26-57</u>			
PHYSICIAN'S NAME (Type) <u>M. C. Porter field M.D.</u>		<u>Hampstead Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Manchester, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Justin E. Donovan</u>		ADDRESS <u>3818 Roland Ave</u>	
24a. RECEIVED BY REGISTRAR <u>DEC 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Ely Gorsuch</u>	

REC 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11639 CERTIFICATE OF DEATH

11649

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Riderwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1406 W Joppa Rd</u>		d. STREET ADDRESS <u>11406 W Joppa Rd</u>	
3. NAME OF DECEASED (Type or print) <u>MABEL MAYNARD SMITH</u>		4. DATE OF DEATH <u>NOV 1</u> 19 <u>57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25 1875</u> 81 yrs.
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Walter Maynard</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Crawford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Francis Abell</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary Atherosclerosis</u> (c) <u>Coronary Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 3/4 hrs</u> <u>1 3/4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1947</u> , to <u>Nov 1, 1957</u> , that I last saw the deceased alive on <u>Nov 1, 1957</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Town A Sedlack</u>		ADDRESS (Street, city or town, state) <u>200 W. Penna. Ave</u> DATE SIGNED <u>11/2/57</u>	
PHYSICIAN'S NAME (Type) <u>Town A. SEDLACK</u>		<u>Towson 4, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 4, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Balto. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons, Co.</u>		ADDRESS <u>4905 York Rd</u>	
24a. REC'D BY REGISTRAR <u>11/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Maynard</u>	

BUREAU V. S.

NOV 5 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11640 CERTIFICATE OF DEATH

Reg. Dist. No. 11650<sup>38</sup>

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 PARKVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2906 MAPLE AVE</u>		d. STREET ADDRESS <u>1 2906 MAPLE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>MATHILDA</u> Middle <u>R</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 12 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert L. Lloyd</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mary Caudle</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca. of large intestine</u> DUE TO (c) <u>10yr.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 1955</u> to <u>Nov 19, 1957</u> , that I last saw the deceased alive on <u>Nov 19, 1957</u> , and that death occurred at <u>10:10</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. A. Grott</u> M.D.		ADDRESS (Street, city or town, state) <u>8100 Hartford Rd.</u> DATE SIGNED <u>11/23/57</u>	
PHYSICIAN'S NAME (Type) <u>H. A. Grott, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Nov 23, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAMM</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans &amp; Son</u> ADDRESS <u>8802 Hartford Rd.</u>		24a. REC'D BY REGISTRAR <u>Nov 26 1957</u>	24b. REGISTRAR'S SIGNATURE <u>J. A. M. Brown</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. S.**

NOV 26 1957

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11641

CERTIFICATE OF DEATH

Reg. Dist. No. 11651

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3811 Edmondson Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>E.</b> Last <b>SMOOT</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 1, 1881</b>	
9. AGE (In years lost birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Randolph R. Henley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bingham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mr. Frederick J. Smoot - 3800 Edmondson Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Generalized Arterio-Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>about 2 years</b> (c)				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1952</b> to <b>Nov. 5</b> 19 <b>57</b> , that I last saw the deceased alive on <b>Nov 2</b> 19 <b>57</b> , and that death occurred at <b>7:30</b> A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julius C. Gluck</b>				ADDRESS (Street, city or town, state) <b>5356 Reisterstown Road Baltimore 15, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Julius C. Gluck, M. D.</b>				DATE SIGNED <b>11-5-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS - B.F.B.</b>				ADDRESS <b>Balto. 17, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 6 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Tickner</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 7 1961

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11642

## CERTIFICATE OF DEATH

Reg. Dist. No.

1165238

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Balto</u> (14) x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9906 Finney Drive</u>		d. STREET ADDRESS <u>9906 Finney Drive</u>	
3. NAME OF DECEASED (Type or print) <u>James Joseph Szyck</u> First Middle Last		4. DATE OF DEATH <u>Nov 27 1957</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 8 1878</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>214-03-6770-A</u>	
13. FATHER'S NAME <u>Joseph Szyck</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Haylick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Artery Occlusion</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Vascular Disease</u> DUE TO (c) <u>Pl. Age</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1954</u> to <u>Nov 1957</u> , that I last saw the deceased alive on <u>Nov 26 1957</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasir, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 HARFORD RD. BALTO 14, Md.</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIR, JR.</u>		DATE SIGNED <u>11/27/57</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-30-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>E. North Ave. Balto Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Walter Conklin</u>		24. REC'D BY REGISTRAR <u>DEC 2 1957</u>	
ADDRESS <u>5444 Belair Rd. Balto 6, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. A. M. Szymanski</u>	

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11843

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES J. JONES		45		M		W		1912		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT	
DEC 1 1957		NEW YORK		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HYPERTENSION		DIABETES		SMOKING	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CHURCH	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

BUREAU V. 8

DEC 2 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11643 CERTIFICATE OF DEATH

116534

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>NEW HAMPSHIRE</b> b. COUNTY <b>GRAFTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>HANOVER</b> 66X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>LYME ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>IVAN</b> Middle <b>D</b> Last <b>STANHOPE</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>30</b> , Year <b>19 57</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 30, 1909</b>
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLERK, RECORDS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>VA CENTER, US GOVT.</b>	
11. BIRTHPLACE (State or foreign country) <b>WINDOSKI, VERMONT</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>HERBERT I STANHOPE</b>		14. MOTHER'S MAIDEN NAME <b>MARY L NOTT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW-11</b>	
17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>IDIOPATHIC HYPERTROPHY OF THE HEART</b> DUE TO (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X LOBULAR PNEUMONIA</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>NOVEMBER 2, 19 57</b> , to <b>NOVEMBER 30, 19 57</b> , that I last saw the deceased <b>live on</b> <b>19</b> , and that death occurred at <b>9:50 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. VAH, Fort Howard, Md.</b> DATE SIGNED <b>12-1-57</b>			
ACTUAL SIGNATURE <b>Donald D. Mark</b>			
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M.D.</b>		<b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12-4-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Gook-Blight, Inc.</b>		24a. REC'D BY REGISTRAR <b>12/2/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Dawson L. Siskley</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

1957

BUREAU V. 8

DEC 4 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 1 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3, 8, 9, 13 & 14 : 11644  
Film G223 11/27/57 GTE

# CERTIFICATE OF DEATH

11654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>16 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pine Nursing Home</b>				d. STREET ADDRESS <b>107 S. Linwood Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Wilhelmina</b> Middle <b>E.</b> Last <b>Stanton</b>				4. DATE OF DEATH Month <b>November</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1886</b> <b>Sept. 9, 1887</b>	
9. AGE (In years last birthday) <b>70 71 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Frank Martin Roth</b>				14. MOTHER'S MAIDEN NAME <b>Henriette Bush, Henrietta Busch</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>11 yes, give war or dates of service</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Paul Braungart</b> Address <b>345 N. Beaumont Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia left</b> <b>490x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Congestive Heart Failure</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arterio sclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Mar 15, 1957</b> to <b>16 Jan 57</b> , that I last saw the deceased alive on <b>15 Jan 19 57</b> , and that death occurred at <b>5:05 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. E. Mc Grath</b> M.D.				ADDRESS (Street, city or town, state) <b>1303 Frederick Rd</b> DATE SIGNED <b>11/16/57</b>			
PHYSICIAN'S NAME (Type) <b>W. E. Mc Grath M.D.</b>				<b>Catonsville Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 20, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 18 57</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Mc Grath</b>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

NOV 19 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11645 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>7yr7mth21dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3v01-4 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>3842 Boarman Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Stark</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Poland</b> ✓	
13. FATHER'S NAME <b>William Blum</b>		14. MOTHER'S MAIDEN NAME <b>Gleka Barsun</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>9047 acute cardiac failure</b> DUE TO (b) <b>Pulmonary edema</b> DUE TO (c) <b>fracture right hip</b> Interval between ONSET AND DEATH <b>Accident</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pt. fell on 10-13-57 while preparing for visitors, sustaining a frac. rt. hip.</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:00 p.m. 10-13 1957</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Catonsville 28, Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Geo. M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11-25-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-26-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Herring Run</b>		22d. LOCATION (City, town, or county) (State) <b>Balto, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc 2100 Eutaw Place</b>		24a. REC'D BY REGISTRAR <b>NOV 26 57</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF EXAMINER		TITLE		DATE		PLACE					

RECEIVED  
BALTIMORE  
NOV 27 1957

BUREAU V. S.

NOV 27 1957

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>7 yrs, 10 mo.</u>		d. STREET ADDRESS <u>1636 Forest Hill Avenue</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Linda</u> Middle <u>Lee</u> Last <u>Staton</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/2/48</u>
9. AGE (In years last birthday) <u>9</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leroy Staton</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Redmond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Rosewood Records</u>	
17. INFORMANT <u>Rosewood Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> DUE TO <u>500 x</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Acute Bronchitis</u> DUE TO (c) <u>Inanition</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 days</u> <u>Birth</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Micro-cephalic Idiot with symptomatic Epilepsy</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:30 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry G. Butler</u> M.D.		ADDRESS (Street, city or town, state) <u>Owings Mills, Md.</u> DATE SIGNED <u>11/12/57</u>	
PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>		<u>Rosewood State Training School</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-14-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u> ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 13 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mary E. Jones</u>

BUREAU V. S.

NOV 13 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11657

Reg. Dist. No. 39

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARKS</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Sparks</u> x0 d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First <u>NORMAN</u> Middle <u>O.</u> Last <u>STERRETT</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1957</u>
9. AGE (In years last birthday) <u>6</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Sparks, Md.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>Norman Otis Sterrett</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Viola Johnson</u> Address <u>Sparks, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PURULENT OTITIS MEDIA</u> 391.2 DUE TO <u>BILATERAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. _____		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. S. FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11/24/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-26-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Steven Son Cam.</u>		22d. LOCATION (City, town, or county) <u>Sparks</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Jackson</u>		24a. REC'D BY REGISTRAR <u>NOV 27 1957</u>	
ADDRESS <u>Funeral Home</u>		24b. REGISTRAR'S SIGNATURE <u>Elizabeth Horvath</u>	
2033/41XV4 916 Penna. AVE. IF 1		E. J.	

11017  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 DEPARTMENT OF HEALTH-BALTIMORE, MD.

BURKAW V. S.

NOV 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11658

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Parkville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7911 Tilmont Avenue</u>				d. STREET ADDRESS <u>1 7911 Tilmont Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. James R. Stow</u> First Middle Last				4. DATE OF DEATH <u>November 11th</u> 19 <u>57</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 16, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S.F. &amp; G.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Stow</u>				14. MOTHER'S MAIDEN NAME <u>Julia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Bernardine Stow, 7911 Tilmont Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis Generalized</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sust</u> <u>undet.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John C. Hyle</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN C. Hyle</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck 5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>NOV 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>R. D. M. Bacon</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
PLACE OF BIRTH		OCCUPATION		EDUCATION		MARRIAGE	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH	
SIGNATURE OF EXAMINER		TITLE		ADDRESS		CITY	
STATE		COUNTY		ZIP CODE		FEDERAL ID	

BUREAU V. S.

NOV 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11649

## CERTIFICATE OF DEATH

11659

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN IB <b>1mth 23dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>4306 Wentworth Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Camelia</b> Middle <b>Mellie</b> Last <b>Streckfus</b>				4. DATE OF DEATH Month <b>11</b> Day <b>3</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 23, 1873</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR: Months <b>11</b> Days <b>3</b> Hours <b>19</b> Min. <b>57</b>		IF UNDER 24 HRS. Months <b>11</b> Days <b>3</b> Hours <b>19</b> Min. <b>57</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>housework</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S.A.</b>			
13. FATHER'S NAME <b>William A. Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Mary Clifford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Abscess</b> DUE TO <b>490x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lobar pneumonia</b> DUE TO <b>4 wk</b> (c) <b>Arteriosclerotic cardiovascular disease</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Oct. 7, 1957</b> to <b>11/3, 1957</b> , that I last saw the deceased alive on <b>11/3, 1957</b> , and that death occurred at <b>5 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>Stella Wachslar</b>							
ACTUAL SIGNATURE <b>Stella Wachslar</b> M.D. <b>SPRING GROVE STATE HOSPITAL</b>							
PHYSICIAN'S NAME (Type) <b>STELLA WACHSLER</b> Catonsville 28, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11-5-1957</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>				22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Howard Strong</b> ADDRESS <b>3207 W. 16th Ave.</b>				24a. REC'D BY REGISTRAR <b>Nov 5 '57</b> 24b. REGISTRAR'S SIGNATURE <b>Aw. L. Smith</b>			



CERTIFICATE OF DEATH

For use in

1. NAME OF DECEASED MARTIN, JAMES		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Nov 10, 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md	
10. DATE OF BIRTH Nov 10, 1912		11. TIME OF BIRTH 10:00 AM		12. PLACE OF BIRTH Baltimore, Md	
13. NAME OF FATHER JAMES MARTIN		14. NAME OF MOTHER MARY MARTIN		15. NAME OF SPOUSE None	
16. NAME OF PHYSICIAN J. H. Smith		17. NAME OF NURSE None		18. NAME OF MINISTER None	
19. NAME OF BURIAL PLACE None		20. NAME OF CEMETERY None		21. NAME OF FUNERAL HOME None	
22. NAME OF CORPSE None		23. NAME OF CARRIER None		24. NAME OF DRIVER None	
25. NAME OF DRIVER None		26. NAME OF DRIVER None		27. NAME OF DRIVER None	
28. NAME OF DRIVER None		29. NAME OF DRIVER None		30. NAME OF DRIVER None	
31. NAME OF DRIVER None		32. NAME OF DRIVER None		33. NAME OF DRIVER None	
34. NAME OF DRIVER None		35. NAME OF DRIVER None		36. NAME OF DRIVER None	
37. NAME OF DRIVER None		38. NAME OF DRIVER None		39. NAME OF DRIVER None	
40. NAME OF DRIVER None		41. NAME OF DRIVER None		42. NAME OF DRIVER None	
43. NAME OF DRIVER None		44. NAME OF DRIVER None		45. NAME OF DRIVER None	
46. NAME OF DRIVER None		47. NAME OF DRIVER None		48. NAME OF DRIVER None	
49. NAME OF DRIVER None		50. NAME OF DRIVER None		51. NAME OF DRIVER None	
52. NAME OF DRIVER None		53. NAME OF DRIVER None		54. NAME OF DRIVER None	
55. NAME OF DRIVER None		56. NAME OF DRIVER None		57. NAME OF DRIVER None	
58. NAME OF DRIVER None		59. NAME OF DRIVER None		60. NAME OF DRIVER None	
61. NAME OF DRIVER None		62. NAME OF DRIVER None		63. NAME OF DRIVER None	
64. NAME OF DRIVER None		65. NAME OF DRIVER None		66. NAME OF DRIVER None	
67. NAME OF DRIVER None		68. NAME OF DRIVER None		69. NAME OF DRIVER None	
70. NAME OF DRIVER None		71. NAME OF DRIVER None		72. NAME OF DRIVER None	
73. NAME OF DRIVER None		74. NAME OF DRIVER None		75. NAME OF DRIVER None	
76. NAME OF DRIVER None		77. NAME OF DRIVER None		78. NAME OF DRIVER None	
79. NAME OF DRIVER None		80. NAME OF DRIVER None		81. NAME OF DRIVER None	
82. NAME OF DRIVER None		83. NAME OF DRIVER None		84. NAME OF DRIVER None	
85. NAME OF DRIVER None		86. NAME OF DRIVER None		87. NAME OF DRIVER None	
88. NAME OF DRIVER None		89. NAME OF DRIVER None		90. NAME OF DRIVER None	
91. NAME OF DRIVER None		92. NAME OF DRIVER None		93. NAME OF DRIVER None	
94. NAME OF DRIVER None		95. NAME OF DRIVER None		96. NAME OF DRIVER None	
97. NAME OF DRIVER None		98. NAME OF DRIVER None		99. NAME OF DRIVER None	
100. NAME OF DRIVER None		101. NAME OF DRIVER None		102. NAME OF DRIVER None	

RECEIVED  
NOV 5 1957  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11650

## CERTIFICATE OF DEATH

11660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebbville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebbville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3000 Rolling Rd.</b>				d. STREET ADDRESS <b>3000 Rolling Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>MAE</b> Last <b>STREEBIG</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 7, 1879</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>John H. Zink</b>				14. MOTHER'S MAIDEN NAME <b>Louisa Swem</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. Elva Streebig - 3000 Rolling Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Melanoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>One year</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10, 1953</b> to <b>Nov. 23, 1957</b> , that I last saw the deceased alive on <b>Nov. 21, 1957</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Edwin L. Pierpont</b> M.D. <b>EDWIN L. PIERPONT</b> <b>8204 LIBERTY Rd., BALTO. 7, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Carroll Chapel Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS</b>				24a. REC'D BY REGISTRAR <b>NOV 25 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>Dr. J. H. Martin</b>							

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		MALE		65		JAN 1 1892		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
BALTIMORE, MD.		LABORER		HEART DISEASE		NATURAL		BALTIMORE, MD.	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		SECONDS OF DEATH	
NOV 25 1957		10 30 AM		10		30		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

NOV 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11661

11651

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>10 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home in The Pines Nursing Home</b>				d. STREET ADDRESS <b>137 Ridgely Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Hugo</b> Middle <b>Suhr</b> Last <b>Sr.</b>				4. DATE OF DEATH Month <b>November</b> Day <b>22</b> , Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 12, 1886</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>3</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant Owner</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Klauser Suhr</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-07-1056</b> <b>220-05-1441</b>		17. INFORMANT Address <b>Johanna L. Suhr 37 Ridgely Rd. Lutherville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>Ca 2 Prostate</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>12 hr.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____	Month, _____	Day, _____	Year, <b>19 57</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State)	
21. I certify that I attended the deceased from <b>11-14</b> , <b>1957</b> , to <b>11-22</b> , <b>1957</b> , that I last saw the deceased alive on <b>11-22</b> , <b>1957</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>6209 Frederick Ave. Catonsville-28, Md.</b>				DATE SIGNED <b>11/23/57</b>			
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>				M.D. <b>6209 Frederick Ave. Catonsville-28, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>Nov. 25/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc. Towson, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 26 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Wm Cook</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Page 2 of 2

NAME OF DECEASED JAMES E. BURKAY		DATE OF BIRTH 1910-01-15		PLACE OF BIRTH BALTIMORE, MD	
MARRIAGE MARRIED		DATE OF MARRIAGE 1935-01-15		PLACE OF MARRIAGE BALTIMORE, MD	
DATE OF DEATH 1957-11-27		PLACE OF DEATH BALTIMORE, MD		CAUSE OF DEATH HEART DISEASE	
TIME OF DEATH 10:00 AM		DATE OF INTERMENT 1957-12-01		PLACE OF INTERMENT BALTIMORE, MD	
NAME OF FUNERAL HOME JAMES E. BURKAY		DATE OF FUNERAL 1957-12-01		PLACE OF FUNERAL BALTIMORE, MD	
NAME OF NEXT OF KIN JAMES E. BURKAY		DATE OF NEXT OF KIN 1957-12-01		PLACE OF NEXT OF KIN BALTIMORE, MD	
NAME OF PHYSICIAN JAMES E. BURKAY		DATE OF PHYSICIAN 1957-12-01		PLACE OF PHYSICIAN BALTIMORE, MD	
NAME OF BURIAL PLACE JAMES E. BURKAY		DATE OF BURIAL 1957-12-01		PLACE OF BURIAL BALTIMORE, MD	
NAME OF CEMETERY JAMES E. BURKAY		DATE OF CEMETERY 1957-12-01		PLACE OF CEMETERY BALTIMORE, MD	
NAME OF INTERMENT JAMES E. BURKAY		DATE OF INTERMENT 1957-12-01		PLACE OF INTERMENT BALTIMORE, MD	
NAME OF DECEASED JAMES E. BURKAY		DATE OF DEATH 1957-11-27		PLACE OF DEATH BALTIMORE, MD	
MARRIAGE MARRIED		DATE OF MARRIAGE 1935-01-15		PLACE OF MARRIAGE BALTIMORE, MD	
DATE OF DEATH 1957-11-27		PLACE OF DEATH BALTIMORE, MD		CAUSE OF DEATH HEART DISEASE	
TIME OF DEATH 10:00 AM		DATE OF INTERMENT 1957-12-01		PLACE OF INTERMENT BALTIMORE, MD	
NAME OF FUNERAL HOME JAMES E. BURKAY		DATE OF FUNERAL 1957-12-01		PLACE OF FUNERAL BALTIMORE, MD	
NAME OF NEXT OF KIN JAMES E. BURKAY		DATE OF NEXT OF KIN 1957-12-01		PLACE OF NEXT OF KIN BALTIMORE, MD	
NAME OF PHYSICIAN JAMES E. BURKAY		DATE OF PHYSICIAN 1957-12-01		PLACE OF PHYSICIAN BALTIMORE, MD	
NAME OF BURIAL PLACE JAMES E. BURKAY		DATE OF BURIAL 1957-12-01		PLACE OF BURIAL BALTIMORE, MD	
NAME OF CEMETERY JAMES E. BURKAY		DATE OF CEMETERY 1957-12-01		PLACE OF CEMETERY BALTIMORE, MD	
NAME OF INTERMENT JAMES E. BURKAY		DATE OF INTERMENT 1957-12-01		PLACE OF INTERMENT BALTIMORE, MD	

BURKAY V. S.

NOV 27 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 11662

11652

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>315 INGLESIDE AVE Catonsville Nursing Home</b>				d. STREET ADDRESS <b>LAUREL 16412</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ELLA MARIE SULLIVAN</b> First Middle Last				4. DATE OF DEATH <b>NOVEMBER 27 1957</b> Month Day Year			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 21 1865</b> 9 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER PRIVATE HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>NOAH W. DONALDSON</b>				14. MOTHER'S MAIDEN NAME <b>ANTOINETTE JAMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lavinia Marie Laurel Md</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA RIGHT BREAST</b> DUE TO <b>METASTASIS -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARSENIC SELECTIVE RADIO-OPACUM DISEASE &amp; PULMONARY OEDEMA</b> DUE TO <b>CLARENIA -</b> (c) <b>CLARENIA -</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>11/24</b> , 19 <b>57</b> , to <b>11/27</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/27</b> , 19 <b>57</b> , and that death occurred at <b>9:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>1800 EMMETT ROAD 11/27/57</b>							
ACTUAL SIGNATURE <b>John H. Shaw</b> M.D.				PHYSICIAN'S NAME (Type) <b>JOHN H. SHAW</b> DATE <b>NOV 28 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV 29 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ELLIOTT CHAPEL CEM</b>		22d. LOCATION (City, town, or county) (State) <b>FORT MEADE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Heath Donaldson, Laurel, Md</b>				24a. REC'D BY REGISTRAR <b>DEC 2</b>		24b. REGISTRAR'S SIGNATURE <b>W. Search</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11653

## CERTIFICATE OF DEATH

116638

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Towson</b>				c. LENGTH OF STAY IN 1b <b>1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eudowood - Towson 4, Md.</b>				d. STREET ADDRESS <b>513 Cattedow St</b>			
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>SULLIVAN</b> Last <b>SULLIVAN</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 18, 1913</b>	
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>29</b> Hours <b>11</b> Min.		IF UNDER 24 HRS. Months <b>11</b> Days <b>29</b> Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weaver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Wallace Rawlings</b>				14. MOTHER'S MAIDEN NAME <b>Dorothy Boswell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Personal History</b> <b>Hospital Records, Eudowood Sanatorium</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b> DUE TO <b>002X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>002X</b> DUE TO (c) <b>002X</b> INTERVAL BETWEEN ONSET AND DEATH <b>11 yr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>May 1956</b> to <b>Nov 29, 1957</b> , that I last saw the deceased alive on <b>Nov 28, 1957</b> , and that death occurred at <b>8:35 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Eudowood Sanatorium</b> DATE SIGNED <b>Nov 28, 1957</b>							
ACTUAL SIGNATURE <b>Milton B. Kress</b> M.D.				Towson 4, Maryland			
PHYSICIAN'S NAME (Type) <b>Milton B. Kress, M.D.</b>				Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/2/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James T. Ryan, Inc.</b> ADDRESS <b>317 Pa. Ave., SE DC 3</b>				24a. REC'D BY REGISTRAR <b>DEG 2 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Michael Gray</b>	

CERTIFICATE OF DEATH

File No. 111

1. NAME OF DECEASED HARRISON		2. SEX MALE		3. AGE 38	
4. OCCUPATION LABORER		5. PLACE OF BIRTH BALTIMORE		6. DATE OF BIRTH JAN 15 1919	
7. PLACE OF DEATH BALTIMORE		8. CAUSE OF DEATH HEART DISEASE		9. MANNER OF DEATH NATURAL	
10. DATE OF DEATH DEC 2 1957		11. TIME OF DEATH 10:00 AM		12. SIGNATURE OF PHYSICIAN J. H. HARRISON	
13. SIGNATURE OF REGISTRAR J. H. HARRISON		14. SIGNATURE OF WITNESS J. H. HARRISON		15. SIGNATURE OF WITNESS J. H. HARRISON	

RECEIVED  
DEC 2 1957  
BUREAU V. S.

## 11654 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED  
(Type or Print)

Elizabeth H. Swartz

2. DATE  
OF  
DEATH

Nov 2 1957

3. PLACE OF DEATH:

A. ~~Baltimore~~ Maryland <sup>104507</sup> Balto. Co.B. FULL NAME OF  
HOSPITAL OR  
INSTITUTIONArmocost Nursing Home  
812 Regester Ave.4. USUAL RESIDENCE (Where deceased lived, if institution; residence  
before admission)A. STATE  
Md.B. COUNTY  
Balto.C. CITY OR TOWN (If outside corporate limits, write RURAL and give  
township)

Lutherville X0

D. STREET ADDRESS (If rural, give location)

226 Meadowvale Rd.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

widowed

8. DATE OF BIRTH

Dec. 12, 1871

9. AGE (In years  
last birthday)

85

If Under 1 Year  
Months: Days  
If Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR  
INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Charles A. B. Howard

14. MOTHER'S MAIDEN NAME

Mary Raughter

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Mr. Joel Swartz - 226 Meadowvale Rd.

18. 422.1

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, aethenia, etc. It means the disease,  
injury or complication which caused death.)(A) Cerebral Thrombosis  
DUE TO arterio sclerosis

4 days

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) myocardial insufficiency  
DUE TO arterio sclerosis  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT  
OR CONTRIBUTING CAUSE OF  
DEATH (NOTIFY MEDICAL EXAMINER)

about home, farm, factory, street, office bldg., etc.)

INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from October 29 1957 to  
Nov. 2 1957, that (I) (we) last saw the deceased alive on Nov. 2 1957,  
and that death occurred at 3:45 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Arman Fried

23B. ADDRESS

#316 Medical Arts Bldg.

23C. DATE SIGNED

Nov. 2 1957

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

11/5/57

24C. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

24D. LOCATION (City, town, or county)

Woodlawn, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

11/5/57

H. G. H. H.

Mrs. L. Pickner &amp; Sons - Balto.

THIS IS A PERMANENT RECORD.  
PLEASE TYPE, OR WRITE IN PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.Every item of information should be fully supplied. Physicians: please write the causes of death clearly and leg-  
HIS CERTIFICATE MUST BE FILM THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

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11655

## CERTIFICATE OF DEATH

11665

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. LENGTH OF STAY IN 1b <u>x2</u> <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2512 Taylor Avenue</u>				d. STREET ADDRESS <u>2512 Taylor Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mr. Charles E. Teague</u>				4. DATE OF DEATH <u>November 9th 1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 1, 1869</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter and Contractor</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Teague</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs. Melvia Back</u>		Address <u>2512 Taylor Avenue</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary emphysema</u> DUE TO (c) <u>Paralysis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 + years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept. 1954</u> , to <u>Nov. 1957</u> , that I last saw the deceased alive on <u>Oct. 31, 1957</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Elliott Harris</u> M.D.				ADDRESS (Street, city or town, state) <u>8100 Harford Road #14</u>		DATE SIGNED <u>11/9/57</u>	
PHYSICIAN'S NAME (Type) <u>S. Elliott Harris</u>				Baltimore, Maryland			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>NOV 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11656 CERTIFICATE OF DEATH

1166644

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u> x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2510 Haddaway Rd.</u>		d. STREET ADDRESS <u>2510 Haddaway Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>W.</u> Last <u>TERRY</u>		4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 8, 1875</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>82</u> Days <u>8</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman, ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wesley Terry ?</u>		14. MOTHER'S MAIDEN NAME <u>Alabama Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph E. Menser - 2601 Brannon Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>20 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1955</u> to <u>Nov 8, 1957</u> , that I last saw the deceased alive on <u>Nov. 8, 1957</u> , and that death occurred at <u>1:39</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>11/8/57</u>			
ACTUAL SIGNATURE <u>David Owens</u> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Nov. 11, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home, Dundalk, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>11/12/57</u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Farley</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Handwritten: John Doe]		2. SEX [Handwritten: Male]		3. AGE [Handwritten: 45]		4. RACE [Handwritten: White]		5. DATE OF BIRTH [Handwritten: 11/15/1910]		6. PLACE OF BIRTH [Handwritten: Baltimore, Md.]	
7. MARITAL STATUS [Handwritten: Married]		8. OCCUPATION [Handwritten: Clerk]		9. CAUSE OF DEATH [Handwritten: Heart Disease]		10. MANNER OF DEATH [Handwritten: Natural]		11. DATE OF DEATH [Handwritten: 11/10/1957]		12. PLACE OF DEATH [Handwritten: Home]	
13. SIGNATURE OF DECEASED [Blank]		14. SIGNATURE OF WITNESS [Handwritten: John Doe]		15. SIGNATURE OF PHYSICIAN [Handwritten: Dr. Smith]		16. SIGNATURE OF CLERK [Handwritten: J. Doe]		17. SIGNATURE OF REGISTRAR [Handwritten: J. Doe]		18. SIGNATURE OF JUDGE [Handwritten: J. Doe]	
19. SIGNATURE OF DECEASED [Blank]		20. SIGNATURE OF WITNESS [Handwritten: John Doe]		21. SIGNATURE OF PHYSICIAN [Handwritten: Dr. Smith]		22. SIGNATURE OF CLERK [Handwritten: J. Doe]		23. SIGNATURE OF REGISTRAR [Handwritten: J. Doe]		24. SIGNATURE OF JUDGE [Handwritten: J. Doe]	
25. SIGNATURE OF DECEASED [Blank]		26. SIGNATURE OF WITNESS [Handwritten: John Doe]		27. SIGNATURE OF PHYSICIAN [Handwritten: Dr. Smith]		28. SIGNATURE OF CLERK [Handwritten: J. Doe]		29. SIGNATURE OF REGISTRAR [Handwritten: J. Doe]		30. SIGNATURE OF JUDGE [Handwritten: J. Doe]	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

37

11657

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>				c. LENGTH OF STAY IN 1b <b>3 MONTHS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROSEWOOD STATE TRAINING SCHOOL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>CHARLES</b> Last <b>THOMAS</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-5-54</b>	
9. AGE (In years last birthday) <b>3</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES L. THOMAS</b>				14. MOTHER'S MAIDEN NAME <b>AGNES HAWKINS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>ROSEWOOD RECORDS OWINGS MILLS, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>431X</b> DUE TO <b>Acute myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congenital cerebral defect of undetermined type</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>8/12</b> , 19 <b>57</b> , to <b>11/18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11/17</b> , 19 <b>57</b> , and that death occurred at <b>4:15 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm. J. Olsen</b>				DATE SIGNED <b>11/26/57</b>			
PHYSICIAN'S NAME (Type) <b>(Body goes to Anatomical Board)</b>				ADDRESS (Street, city or town, state) <b>Rosewood Lane Owings Mills, Md.</b>			
22a. BURIAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>REMOVAL</b>		<b>11/22/57</b>		<b>U.S. Ind. Nat. School</b>		<b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. H. Newell - Pikesville - MD.</b>				24a. REC'D BY REGISTRAR DATE <b>11/26/57</b>		24b. REGISTRAR'S SIGNATURE <b>Mary Elmer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 11658 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>1yr10mths17dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Beatrice</b> Middle <b>Maud</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>19 57</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 15, 1883</b>	
9. AGE (In years last birthday) <b>74 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Housing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>unknown James H. Thompson</b>				14. MOTHER'S MAIDEN NAME <b>unknown Eliza Elya Shoemaker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-03-0801</b>		17. INFORMANT Address <b>Record s: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis, generalized and severe</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 31</b> , 19 <b>57</b> , to <b>Nov. 12</b> , 19 <b>57</b> that I last saw the deceased alive on <b>Nov. 12</b> , 19 <b>57</b> , and that death occurred at <b>8:00 a.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stella Wachslar</b>				DATE SIGNED <b>11-12-57</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CHURCH CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>FOREST GLEN, MONT. CO., Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Galt</b>				24a. REGISTERED BY REGISTRAR <b>Nov 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11669

11659 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>111 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>T.</u> Last <u>TISDALE</u>				4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Transfer Company</u>		11. BIRTHPLACE (State or foreign country) <u>Lunenburg, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Tisdale</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>217-07-0530</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate with boney and urinary</u> <u>177X</u> <del>XXXXXX</del> <u>bladder metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> (c) <u>  </u> DUE TO (b) <u>  </u> (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>1957</u> Hour o. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 31</u> 19 <u>57</u> , to <u>November 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>XXXXX</u> and that death occurred at <u>1:50 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Fort Howard, Maryland</u> DATE SIGNED <u>11/20/57</u>							
ACTUAL SIGNATURE <u>Chien Wei Lan</u>				M.D. <u>Veterans Administration Hospital</u>			
PHYSICIAN'S NAME (Type) <u>CHIEN WEI LAN, M.D.</u>				<u>Fort Howard, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-25-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law Mortuary, 802-04 Madison Ave. Balto</u>				24a. REC'D BY REGISTRAR <u>NOV 25 1957</u>			
24b. REGISTRAR'S SIGNATURE <u>Hawson &amp; L. Parker</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. MARITAL STATUS		7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH	
11. DATE OF DEATH		12. TIME OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN		19. SIGNATURE OF BURIAL OFFICIAL		20. SIGNATURE OF FUNERAL HOME	
21. SIGNATURE OF CORONER		22. SIGNATURE OF JURY		23. SIGNATURE OF JUDGE		24. SIGNATURE OF DISTRICT ATTORNEY		25. SIGNATURE OF COUNTY CLERK	
26. SIGNATURE OF STATE DEPARTMENT OF HEALTH		27. SIGNATURE OF BALTIMORE CITY DEPARTMENT OF HEALTH		28. SIGNATURE OF ANN ARBOR DEPARTMENT OF HEALTH		29. SIGNATURE OF ANNAPOLIS DEPARTMENT OF HEALTH		30. SIGNATURE OF BETHESDA DEPARTMENT OF HEALTH	
31. SIGNATURE OF BOWLING GREEN DEPARTMENT OF HEALTH		32. SIGNATURE OF CROFTON DEPARTMENT OF HEALTH		33. SIGNATURE OF ELLICOTT CITY DEPARTMENT OF HEALTH		34. SIGNATURE OF FARMERSBURGH DEPARTMENT OF HEALTH		35. SIGNATURE OF GAITHERSBURG DEPARTMENT OF HEALTH	
36. SIGNATURE OF GREENBELT DEPARTMENT OF HEALTH		37. SIGNATURE OF HAGERSTOWN DEPARTMENT OF HEALTH		38. SIGNATURE OF JESSELTON DEPARTMENT OF HEALTH		39. SIGNATURE OF LAUREL DEPARTMENT OF HEALTH		40. SIGNATURE OF LEXINGTON DEPARTMENT OF HEALTH	
41. SIGNATURE OF LITTLE ROCK DEPARTMENT OF HEALTH		42. SIGNATURE OF LUTHERSBURG DEPARTMENT OF HEALTH		43. SIGNATURE OF MARYLAND BEACH DEPARTMENT OF HEALTH		44. SIGNATURE OF MILLERSVILLE DEPARTMENT OF HEALTH		45. SIGNATURE OF Pikesville DEPARTMENT OF HEALTH	
46. SIGNATURE OF PRAIRIE DEPARTMENT OF HEALTH		47. SIGNATURE OF ROCKVILLE DEPARTMENT OF HEALTH		48. SIGNATURE OF SEABOARD DEPARTMENT OF HEALTH		49. SIGNATURE OF SEWYER DEPARTMENT OF HEALTH		50. SIGNATURE OF SILVER SPRING DEPARTMENT OF HEALTH	
51. SIGNATURE OF SPRINGFIELD DEPARTMENT OF HEALTH		52. SIGNATURE OF THURMONT DEPARTMENT OF HEALTH		53. SIGNATURE OF WASHINGTON DEPARTMENT OF HEALTH		54. SIGNATURE OF WILMINGTON DEPARTMENT OF HEALTH		55. SIGNATURE OF YORK DEPARTMENT OF HEALTH	

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NOV 25 1967  
BUREAU V. S.

Item 18 Film 223 12-17-57 ams

11660

## CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>				c. LENGTH OF STAY IN TB <b>3 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b> <b>3Y01-4</b> ✓			
f. STREET ADDRESS <b>1008 Bond Street</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret Toles</b>				4. DATE OF DEATH Month Day Year <b>11 14 19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/24/50</b>	
9. AGE (In years last birthday) <b>7</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Amos Smith</b>				14. MOTHER'S MAIDEN NAME <b>Emma Toles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Rosewood Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b> <b>309X</b> DUE TO <b>Chronic brain syndrome</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Decreased activity</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>11/14/57</b> <b>11/14/57</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at: <b>2:25 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rosewood State Training School</b> DATE SIGNED <b>11/15/57</b>							
ACTUAL SIGNATURE <b>Conrado Bogaert, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Conrado Bogaert, M.D.</b> <b>Rosewood State Training School</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>buried</b>				22b. DATE THEREOF <b>11/15-19-57</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Not Calvary Cemetery A. A. B. Md</b>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Williams</b> ADDRESS <b>1701 N. Bond</b>				24a. RECD BY REGISTRAR <b>NOV 21 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Mary E. King</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

## 11661 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Balto</b> b. COUNTY <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				c. LENGTH OF STAY IN 1b <b>63 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2944 Old North Point Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Chaster Tomczewski</b>				4. DATE OF DEATH Month Day Year <b>II 21 1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19-1880</b>	9. AGE (In years last birthday) <b>77 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel industry</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Tomczewski</b>				14. MOTHER'S MAIDEN NAME <b>Marcia ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>2I3-07-6789</b>		17. INFORMANT Address <b>Clara Kopera 3922 Old North Point Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>10 years</b> <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>JAN 1944</b> to <b>Nov 21, 1957</b> , that I last saw the deceased alive on <b>Nov 20, 1957</b> , and that death occurred at <b>7:45 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>David H. Andrew</b> M.D.				ADDRESS (Street, city or town, state) <b>33 Dundalk Ave</b>		DATE SIGNED <b>11/22/57</b>	
PHYSICIAN'S NAME (Type) <b>David H. Andrew</b>				<b>Dundalk 22171</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>II-25-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST Stanislaus</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Dabrowski</b> ADDRESS <b>1001 Dundalk Ave</b>				24a. REC'D BY REGISTRAR <b>NOV 25 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Edith Hurley</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Figure 1. The effect of the concentration of the solution on the adsorption of the dye.

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MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/SS

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11663

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>405 Alleghany Ave.</b>				e. STREET ADDRESS <b>405 Alleghany Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>ROLAND</b> Last <b>TUCKER</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 6, 1888</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>George W. Tucker</b>				14. MOTHER'S MAIDEN NAME <b>Mary Frances Taylor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mr. Donald W. Tucker - 405 Alleghany Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Hypertension cardiovascular renal disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 min. 15 yrs.				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October</b> , 19 <b>55</b> , to <b>November 25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>November 22</b> , 19 <b>57</b> , and that death occurred at <b>8:30 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3902 Greenmount Avenue</b> DATE SIGNED <b>Nov. 26, 1957.</b>							
ACTUAL SIGNATURE <b>Lloyd E. Saylor</b>		M.D. <b>3902 Greenmount Avenue</b>		DATE SIGNED <b>Nov. 26, 1957.</b>			
PHYSICIAN'S NAME (Type) <b>Lloyd E. Saylor, M. D.</b>		<b>Baltimore 18, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM J. TICKNER &amp; SONS</b>				ADDRESS <b>Balto., Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11/26/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		65		JAN 15 1892		BALTIMORE		MD		USA		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
RETIRED		HEART DISEASE		NATURAL		JAN 25 1957		BALTIMORE		MD		USA		USA	
EDUCATION		RELIGION		MARITAL STATUS		DATE OF MARRIAGE		NAME OF SPOUSE		CITY		STATE		COUNTRY	
HIGH SCHOOL		METHODIST		MARRIED		JAN 15 1915		JAMES H. HARRIS		BALTIMORE		MD		USA	
FATHER'S NAME		MOTHER'S NAME		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		JAMES H. HARRIS		JAN 25 1957		BALTIMORE		MD		USA		USA		JAMES H. HARRIS	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		SIGNATURE OF REGISTRAR		DATE OF DEATH		PLACE OF DEATH	
JAN 25 1957		BALTIMORE		MD		USA		USA		JAMES H. HARRIS		JAN 25 1957		BALTIMORE	
FATHER'S NAME		MOTHER'S NAME		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		JAMES H. HARRIS		JAN 25 1957		BALTIMORE		MD		USA		USA		JAMES H. HARRIS	

BUREAU V. S.

NOV 27 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11664 CERTIFICATE OF DEATH

11674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>19 57</b>				5. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Baltimore (21)</b>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>D</b> Last <b>TYLER</b>				6. STREET ADDRESS <b>100 N. Stuart Street</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/22/74</b>	
9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>		IF UNDER 24 HRS. Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William R. Tyler</b>				14. MOTHER'S MAIDEN NAME <b>Jenny Andrews</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes SAW</b>				16. SOCIAL SECURITY NO. <b>214-20-3849</b>			
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ELECTROLYTIC IMBALANCE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>420.0</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November 6, 19 57</b> to <b>November 22, 19 57</b> and that death occurred at <b>9:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Vincent S Mikolowski</b> M.D.				ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>VINCENT S MIKOLOSKI</b>				M.D. <b>M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>Nov. 26-57</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL CEMETERY</b>				22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MARYLAND</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J G CONNELLY &amp; SONS</b>				ADDRESS <b>418 Eastern Ave Balto 21 Md</b>			
24a. REC'D BY REGISTRAR <b>NOV 26 1957</b>				24b. REGISTRAR'S SIGNATURE <b>Lawson L. Taylor</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11675

Reg. Dist. No.

11665

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stevenson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hillside Road near Falls Road</b>		d. STREET ADDRESS <b>2513 Linden Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>MONTE</b> Middle Last <b>UDOFF</b>		4. DATE OF DEATH Month <b>11</b> Day <b>15</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1936</b>
9. AGE (In years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dental College</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Barney Udoff</b>		14. MOTHER'S MAIDEN NAME <b>Lucille Lederer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Family information</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOTGUN WOUND OF HEAD</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>PAUL F. GUERIN</b>		DATE SIGNED <b>11-16-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Nov. 16, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hirsch &amp; Sons</b>		22d. LOCATION (City, town, or county) (State) <b>No 1225 Jerome Ave., New York, N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons</b>		ADDRESS <b>Towson, Maryland</b>	
24a. REC'D BY REGISTRAR <b>NOV 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Kennedy</b>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Examination		Time of Examination		Place of Examination	
Signature of Physician		Signature of Nurse		Signature of Hospital	
Signature of Family		Signature of Friends		Signature of Community	
Signature of Church		Signature of School		Signature of Government	
Signature of Other		Signature of Other		Signature of Other	

BUREAU V. S.

NOV 20 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11676

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b <b>3 YRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>813 LOYOLA DRIVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HOWARD KIRK UNRUH</b>		4. DATE OF DEATH Month Day Year <b>NOV. 15 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-16</b>
9. AGE (In years last birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRUCKING</b>	
11. BIRTHPLACE (State or foreign country) <b>PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>IRVIN M. UNRUH</b>		14. MOTHER'S MAIDEN NAME <b>LIGHTCAP</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>W.W.I.</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>WIFE, MRS. DORIS</b>		Address <b>813 LOYOLA DR.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>20 MIN.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UPPER RESPIRATORY INFECTION</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>WILLIAM A. PILLSBURY</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>11/15/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 19, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons</b>		ADDRESS <b>Towson, Md.</b>	
24a. REC'D BY REGISTRAR <b>Nov. 19, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	

NOV 20 1957

RECEIVED

## 11667 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>53 Dundalk</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u>		d. STREET ADDRESS <u>3428 Yardley Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>A</u> Last <u>VAN LILL</u>		4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1880</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Packing Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Van Lill</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Blum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Bo.</u>	
17. INFORMANT <u>Mrs. Mary E. Van Lill</u>		Address <u>3428 Yardley Drive-22</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO <u>Amputation mid thigh Right Femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congruent left foot &amp; heel</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus Ulcers Sacrum; Paronychia Acute left.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 10, 1957</u> , to <u>17 Nov 57</u> , that I last saw the deceased alive on <u>16 Nov 57, 19</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. McGreth</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1303 Frederick Rd. 11/19/57</u>	
PHYSICIAN'S NAME (Type) <u>W. E. McGreth</u>		<u>Catonsville 28md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 21, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 21 57</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. E. McGreth</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED



116788

## 11668 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: 335-Dixie Dr.		2. USUAL RESIDENCE (HOME) OF DECEASED: 335-Dixie Dr.	
COUNTY TOWSON, BALTO, 4	MARYLAND Md.	STATE Md.	COUNTY TOWSON, 4
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWSON	LENGTH OF STAY (in this place) TOWSON-RURAL	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWSON	55 TOWSON
HOSPITAL OR INSTITUTION OR STREET ADDRESS 335 Dixie Drive		STREET ADDRESS (If rural give location) 335-DIXIE DR.	

3. NAME OF DECEASED: (First) L. (Middle) GUY (Last) WATKINS		4. DATE OF DEATH: (Month) 11 (Day) 25 (Year) 19 57	
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: Sept. 5, 1896
9. AGE last birthday: 61 yrs.		10. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: salesman	
11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: William J. Watkins		14. MOTHER'S MAIDEN NAME: Ida Elizabeth Wheatley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) yes World No 1		16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: Mrs. Marie E. Watkins - 335 Dixie Drive	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) CORONARY OCCLUSION		immediate
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ARTERIOSCLEROTIC CHANGES		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 322.1 ALCOHOLISM - CHRONIC		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1952, to present, 1957, that I last saw the deceased alive on 11/2, 1957, and that death occurred at 5:15 AM, from the causes and on the date stated above.

SIGNATURE: Joseph P. Ransom (Degree or title) ADDRESS: 1515 - MARTIN BLVD - BALTO, MD. DATE SIGNED: 11/25/57

23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF: 11/27/57	NAME OF CEMETERY OR CREMATORY: Lorraine Cem.	LOCATION (City, town, or county) (State): Woodlawn, Md.
DATE REC'D BY LOCAL REGISTRAR: 11/27/57	REGISTRAR'S SIGNATURE: Mabel Gray	24. FUNERAL DIRECTOR: Mrs. J. Pickner & Sons	ADDRESS: Balto, 17 Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 3 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

116794

Reg. Dist. No.

11669

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3Y01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>3500 E. Fayette Street</b>	
3. NAME OF DECEASED (Type or print) First <b>ADAM</b> Middle <b>J.</b> Last <b>WEININGER</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/16/95</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Weininger</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Fuchs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>215-14-8865</b>	
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OESOPHAGUS</b> <b>150x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>UNDETERMINED</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 27, 19 57</b> , to <b>November 11, 19 57</b> , and that death occurred at <b>8:50A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>11/11/57</b> ACTUAL SIGNATURE <b>HOWARD C. KRAMER, M. D.</b> PHYSICIAN'S NAME (Type) <b>Fort Howard, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-14-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Zeiler</b> ADDRESS <b>901 S. CONKLING ST. BALTO., MD.</b>		24a. REC'D BY REGISTRAR DATE <b>11/13/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Darwin L. Harber</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
OCCUPATION		EDUCATION		MARRIAGE	
DATE OF DEATH		PLACE OF DEATH		CITY	
CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANCE	
DATE OF BURIAL		PLACE OF BURIAL		CITY	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
CITY OF SIGNATURE		CITY OF SIGNATURE		CITY OF SIGNATURE	
STATE OF SIGNATURE		STATE OF SIGNATURE		STATE OF SIGNATURE	
COUNTRY OF SIGNATURE		COUNTRY OF SIGNATURE		COUNTRY OF SIGNATURE	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
CITY OF DEATH		CITY OF DEATH		CITY OF DEATH	
STATE OF DEATH		STATE OF DEATH		STATE OF DEATH	
COUNTRY OF DEATH		COUNTRY OF DEATH		COUNTRY OF DEATH	
DATE OF BURIAL		DATE OF BURIAL		DATE OF BURIAL	
PLACE OF BURIAL		PLACE OF BURIAL		PLACE OF BURIAL	
CITY OF BURIAL		CITY OF BURIAL		CITY OF BURIAL	
STATE OF BURIAL		STATE OF BURIAL		STATE OF BURIAL	
COUNTRY OF BURIAL		COUNTRY OF BURIAL		COUNTRY OF BURIAL	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
CITY OF SIGNATURE		CITY OF SIGNATURE		CITY OF SIGNATURE	
STATE OF SIGNATURE		STATE OF SIGNATURE		STATE OF SIGNATURE	
COUNTRY OF SIGNATURE		COUNTRY OF SIGNATURE		COUNTRY OF SIGNATURE	

BUREAU V. 3

NOV 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11670 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11680 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Balto.</u>		c. LENGTH OF STAY IN 1b <u>17 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural---Baltimore</u> X2		d. STREET ADDRESS <u>8207 Loch Raven Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8207 Loch Raven Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>M.</u> Last <u>Wilkinson Sr</u>		4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steamfitter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Wilkinson</u>		14. MOTHER'S MAIDEN NAME <u>Martha Hyson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-18-9687</u>	
17. INFORMANT <u>Ethel W. Wilkinson</u>		Address <u>8207 Loch Raven Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Subsided</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		ADDRESS <u>3000 E. Balto. St. Balto. Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>J. R. M. Bacon</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

X

RECEIVED  
NOV 19 1957  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11671

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11681

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDGEMERE 19</b>		c. LENGTH OF STAY IN 1b <b>VISIT</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 EDGEMERE 19</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ROUTE 10 - NORTH PT. RD</b>				1d. STREET ADDRESS <b>NORTH POINT RD ROUTE 10 BOX 377</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LESTER</b> Middle <b>PAUL</b> Last <b>WILSON</b>				4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/27/1910</b>	9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOTIVE</b>		11. BIRTHPLACE (State or foreign country) <b>PENN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS WILSON</b>				14. MOTHER'S MAIDEN NAME <b>CARRIE MICKEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>162-12-424</b>		17. INFORMANT <b>SYLVIA L. WILSON - SAME</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Occlusion</b> (c) <b>Coronary Occlusion</b> DUE TO <b>Coronary Occlusion</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Occlusion</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Heart</b>					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M.B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/12/57</b>			
EXAMINER'S NAME (Type) <b>M.B. DAVIS MD</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/13/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WILLIAM LIND MEM</b>		22d. LOCATION (City, town, or county) (State) <b>LEWISTOWN PA</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter B. Bradley, Dundalk, Md.</b>		ADDRESS <b>Walter B. Bradley, Dundalk, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dawson L. Farber</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH & WELFARE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 13 1967

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11672

## CERTIFICATE OF DEATH

11682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>12 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>J.</b> Last <b>WOLF, SR.</b>		4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/9/87</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Wolf</b>		14. MOTHER'S MAIDEN NAME <b>Christine Wineholt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>213-10-2049</b>	
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hosp., Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PROSTATE WITH METASTASIS TO BONES</b> <b>1777X</b> <b>DEATH AND LIVER AND LYMPH NODES</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>October 28</b> , 19 <b>57</b> , to <b>November 9</b> , 19 <b>57</b> , that I last saw the deceased <b>alive on</b> <b>12:15 AM</b> and that death occurred at <b>12:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Veterans Administration Hospital</b> DATE SIGNED <b>11/9/57</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>Chien Wei Lan</b> PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M. D.</b> <b>Fort Howard, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 13 - 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHAS. F. EVANS &amp; SON</b>		24a. REC'D BY REGISTRAR <b>NOV 12 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Lawson L. Farley</b>			

VS A15 (4)  
15M 9/55

Charles F. Evans &amp; Sons Funeral Home, 8802 Harford Rd, Balto., Md.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

PLACE OF DEATH		MARRIAGE		EDUCATION	
AT HOME		MARRIED		SCHOOL	
HOSPITAL		SINGLE		COLLEGE	
NURSING HOME		DIVORCED		UNIVERSITY	
OTHER		WIDOWED		OTHER	
DATE OF DEATH		DATE OF MARRIAGE		DATE OF GRADUATION	
1957		1957		1957	
TIME OF DEATH		TIME OF MARRIAGE		TIME OF GRADUATION	
10:00 AM		10:00 AM		10:00 AM	
CAUSE OF DEATH		CAUSE OF MARRIAGE		CAUSE OF GRADUATION	
HEART DISEASE		LOVE		ACADEMIC	
MURDER		FAMILY		SCIENTIFIC	
SUICIDE		FRIENDS		LITERARY	
OTHER		OTHER		OTHER	
DATE OF BIRTH		DATE OF BIRTH		DATE OF BIRTH	
1957		1957		1957	
TIME OF BIRTH		TIME OF BIRTH		TIME OF BIRTH	
10:00 AM		10:00 AM		10:00 AM	
PLACE OF BIRTH		PLACE OF BIRTH		PLACE OF BIRTH	
AT HOME		AT HOME		AT HOME	
HOSPITAL		HOSPITAL		HOSPITAL	
NURSING HOME		NURSING HOME		NURSING HOME	
OTHER		OTHER		OTHER	

100-60000-100

**RECEIVED**  
 NOV 12 1957  
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 7 and 8 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11683

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3y01-4</b>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Mary</b> Last <b>Yeager</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1895</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>machine operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>office machine</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Yeager</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Schwarzkopf</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-05-3063</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Astrocytoma, right parietal lobe</b> <b>193X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 24</b> , 19 <b>57</b> , to <b>Nov. 13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 13</b> , 19 <b>57</b> , and that death occurred at <b>8:45a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 11-13-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-16-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>FARLEY FUNERAL HOME-CATONSVILLE</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 15 '57</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Form D-2, Rev. 10-1-56

1. NAME OF DECEASED <b>JOHN J. ROY</b>		2. SEX <b>MALE</b>		3. RACE <b>WHITE</b>		4. DATE OF BIRTH <b>12-15-1915</b>		5. PLACE OF BIRTH <b>NEW YORK, N.Y.</b>	
6. DATE OF DEATH <b>11-15-1967</b>		7. PLACE OF DEATH <b>NEW YORK, N.Y.</b>		8. CAUSE OF DEATH <b>HEART DISEASE</b>		9. MANNER OF DEATH <b>NATURAL</b>		10. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>	
11. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		12. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		13. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		14. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>		15. SIGNATURE OF WITNESS <b>JOHN J. ROY</b>	
16. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		17. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		18. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		19. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		20. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
21. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		22. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		23. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		24. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		25. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
26. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		27. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		28. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		29. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		30. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
31. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		32. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		33. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		34. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		35. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
36. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		37. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		38. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		39. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		40. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
41. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		42. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		43. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		44. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		45. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
46. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		47. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		48. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		49. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		50. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
51. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		52. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		53. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		54. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		55. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
56. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		57. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		58. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		59. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		60. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
61. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		62. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		63. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		64. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		65. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
66. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		67. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		68. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		69. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		70. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
71. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		72. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		73. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		74. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		75. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
76. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		77. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		78. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		79. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		80. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
81. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		82. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		83. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		84. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		85. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
86. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		87. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		88. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		89. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		90. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
91. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		92. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		93. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		94. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		95. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	
96. SIGNATURE OF DECEASED <b>JOHN J. ROY</b>		97. SIGNATURE OF NEXT OF KIN <b>JOHN J. ROY</b>		98. SIGNATURE OF PHYSICIAN <b>JOHN J. ROY</b>		99. SIGNATURE OF CLERK <b>JOHN J. ROY</b>		100. SIGNATURE OF REGISTRAR <b>JOHN J. ROY</b>	

BUREAU V. S.

NOV 15 1967

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FOR STATE  
HEALTH DEPT.

11674

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11684

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>	
c. LENGTH OF STAY IN 1b <u>66 yrs</u>		55	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>112 E. CHESAPEAKE AVE.</u>		d. STREET ADDRESS <u>112 E. CHESAPEAKE AVE</u>	
3. NAME OF DECEASED (Type or print) <u>JOSEPH E. YOUNG</u>		4. DATE OF DEATH Month <u>11</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 9, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JOCKEY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RACE HORSES MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>OLIVER YOUNG</u>		14. MOTHER'S MAIDEN NAME <u>LAURENIA BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-K-3597</u>	
17. INFORMANT <u>THOS. YOUNG-315 LENNOX AVE. TOWSON, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (b) <u>HYPERTENSIVE CARDIO RENAL</u> (a), stating the underlying cause last. (c) <u>VASCULAR DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u> Interval between onset and death <u>70 yrs</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles F O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Charles F O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>	22d. LOCATION (City, town, or county) (State) <u>Towson, Balto Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Am. L. Chatman</u>		24. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW STATE  
HEALTH DEPT

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STATE OF NEW YORK

BUREAU V. S.

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